



APPLICATION FOR SPOUSE / PARTNER MEDICAL BENEFITS (to be completed by the insured)

IDENTIFICATION OF THE INSURED

Surname and first name: _____
 Maiden Name: _____
 Address: _____

Family situation ⁽¹⁾:
 married on _____ Monegasque legal civil partnership (CVC) on _____
 divorced on _____
 separated on _____ Other legal civil partnership (incl. PACS) on _____

Do you have any professional activity outside? yes no

If so, please specify the type of activity and the country in which it takes place⁽²⁾ _____

ID Number(s):
C.C.S.S. or C.A.M.T.I. : _____

S.S.F. ID Number:

IDENTIFICATION OF SPOUSE / PARTNER

Surname and first name: _____
 Maiden Name: _____
 Date of birth: _____
 Address : _____

Last organisation responsible for medical benefits ⁽³⁾

ID Number(s):
 C.C.S.S. : _____
 C.A.M.T.I. : _____
 S.P.M.E. : _____
 S.S.F. ID Number:

SPOUSE / PARTNER'S ACTIVITY

Does your spouse / partner have a salaried professional activity? ⁽⁴⁾ yes / no

Does your spouse / partner have a self-employed or liberal profession activity? ⁽⁵⁾ yes / no

If so, please specify the type of activity ⁽²⁾ and the country in which it takes place _____

Otherwise, please indicate last activity: _____

Date of cessation of these activity: _____ Reason for cessation: _____

COMPENSATION OF SPOUSE / PARTNER

Does your spouse / partner receive compensation/pension/benefits for⁽⁶⁾:

				Organisation	From:
- Unemployment	yes	/	no	_____	_____
- Disability	yes	/	no	_____	_____
- Workplace accident	yes	/	no	_____	_____
- Retirement	yes	/	no	_____	_____
- Other (please specify)	yes	/	no	_____	_____

I hereby certify that the information given above is accurate and agree to inform you immediately of any change that takes place subsequent to this application. I understand that any false information or non-declaration of changes in situation may entail a request for reimbursement of care unduly paid.

Monaco, on _____

Signed by the insured



ADDITIONAL FORM TO BE FILLED IN BY THE SPOUSE NAMED IN THE APPLICATION

I the undersigned, _____

residing at _____

bearing Identity card / residence permit (copy attached) no. _____

delivered at _____ valid until _____

hereby certify:

that I am not engaged in any occupational, commercial, craft or liberal activity, I have no retirement pension,

I do not have a retirement pension,

I receive no unemployment benefits from France Travail or any other mechanism,

I receive no disability pension,

I receive no compensation for work-related accident.

I agree to inform the Caisse Sociale de Monaco immediately:

- of any resumption in occupational, commercial, craft or liberal activity,

- of payment of a retirement pension or any other compensation in France, Monaco or any other country for benefits in kind from health insurance.

Drawn up in _____ on _____

Signed (preceded by the words "read and approved")

IMPORTANT

Any affiliation agreement for your spouse will be delivered for a maximum period of one year after which a new request must be submitted by the insured right holder.

All false information or non-declaration of changes in situation may entail a request for reimbursement of care unduly paid.

INCOMPLETE REQUESTS WILL BE RETURNED

DOCUMENTS TO ATTACH:

- (1) copy of the marriage certificate, separation document or divorce decree
Monegasque legal civil partnership (CVC) or termination of CVC declaration issued by the Greffe Général de Monaco
PACS or termination of PACS: birth certificate with marginal entries
proof of foreign civil contract
- (2) proof of activity
- (3) up-to-date certificate of entitlement
- (4) copy of pay slips
- (5) copy of the K-bis, RCI, etc.
- (6) proof of attribution or payment

NB: All documents in a foreign language must be translated into French.