APPLICATION FORM 2017

EURO COVER +





EURO COVER + APPLICATION FORM

Insurance consultant reference number: 181897

Are you already customer at APRIL International Expat? YES NO	If ves. please indicate your Customer Number:	С				
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PLEASE WRITE IN CAPITAL LETTERS

INSURED Person(s) to be insur	red						
If you have more than 3 dependent children, please photocopy page 2 and fill it out.							
Title of principal insured:	Mrs O Mr O						
Surname of principal insured:							
First names of principal insured:	First names of principal insured:						
Date of birth:							
Country of nationality:							
Host country:							
Anticipated length of expatriation:	years						
Occupation:							
Business sector:							
Are you, or any of your family membe	ers, a Politically Exposed Person*? YES NO						
Email:							
Title of spouse : Mrs	s Mr O						
Surname of spouse :							
First names of spouse :							
Date of birth:	m						
Country of nationality:							
Host country:							
Occupation:							
Business sector:							
Is your spouse, or any of their family r	members, a Politically Exposed Person*? YES NO						
Surname of 1st dependent child:							
First names of 1st dependent child:							
Date of birth:	Date of birth: d d Sex: Male Female Female						
Surname of 2 nd dependent child:							
First names of 2 nd dependent child:							
Date of birth:	d d / m m / y y y y Sex: Male Female						
Surname of 3 rd dependent child:							
First names of 3 rd dependent child:							
Date of birth:	d d / m m / y y y y Sex: Male Female						

*Person residing outside France who holds or has within the last year held a prominent political, judicial or administrative position in a country other than France, or on behalf of a public international body.

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	Any correspondence from us (your insurance certificate, General conditions, reimbursement statements etc.) will be sent by e-mail.																																			
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	Your insurance card will be sent by post. I would like to receive my correspondence in: English French Spanish German																																			
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CHOICE OF BENEFITS AND LEVELS OF COVER (CONTINUED)							
4.2 / Repatriation assistance cover							
Membership: Oindividual Ocouple Oprincipal insured + Uchild/children Ofamily (3 individuals or more)							
Location of the country of nationality: ○ European and Mediterranean countries ○ Rest of the world The zone selected will depend on the location of your country of nationality. ► Annual premium (all taxes included): €							
The zone selected will depend on the location of your country of nationality. ► Annual premium (all taxes included): €							
4.3 / Personal liability - private capacity - and legal assistance cover (must be combined with another type of cover under the policy)							
• SINGLE PREMIUM PER POLICY ► Annual premium (all taxes included): €							
4.4 / Death and total and irreversible loss of autonomy cover							
• INDIVIDUAL MEMBERSHIP ONLY							
This option is available to the spouse if the spouse is expatriated also. Depending on the level of benefit selected, certain medical formalities may be required. Please refer to page 14 of the brochure.							
Principal insured French Social Security number (if applicable):							
Amount of cover requested (between €20,000 and €400,000): € (amount doubled in case of death by accident)							
► Annual premium (all taxes included): €							
French Social Security number (if applicable):							
Amount of cover requested (between €20,000 and €400,000): € (amount doubled in case of death by accident)							
► Annual premium (all taxes included): € ☐ ☐ ☐							
Name of beneficiaries (individuals only)							
Principal insured: I name as beneficiary (or beneficiaries) in the event of my death:							
My surviving spouse on condition that we were not legally separated when the lump sum became payable; second, equally, my children living, to be born or represented as such; third, equally my ascendants and fourth my other heirs.							
Other beneficiaries (please specify their surname(s), name(s), date and place of birth and percentage of the capital to be allocated):							
Spouse: I name as beneficiary (or beneficiaries) in the event of my death:							
My surviving spouse on condition that we were not legally separated when the lump sum became payable; second, equally, my children living, to be born or represented as such; third, equally my ascendants and fourth my other heirs.							
Other beneficiaries (please specify their surname(s), name(s), date and place of birth and percentage of the capital to be allocated):							
Carlot beneficialles (piedes specify their surface), name(s), name(s), date and piedes of bital and personnegs of the supractice be directed).							
In the absence of a precise designation of the beneficiaries, the death benefit shall be transferred to the surviving spouse on condition that you were not legally separated							
when the lump sum became payable; second, equally, to the children living, to be born or represented as such; third, equally to the ascendants and fourth to the other heirs.							
4.5 / Income protection cover							
(must be combined with death and total and irreversible loss of autonomy cover; the amount of the daily benefit depends on the level of death benefits you have selected.							
For example, to receive €20 per day, you must have selected death benefits of at least €20,000)							
INDIVIDUAL MEMBERSHIP ONLY This option is available to the spouse only if the spouse is expatriated also.							
Depending on the level selected, certain medical formalities may be required. Please see page 15 of the brochure.							
Principal insured • Amount of daily benefit requested (between €20 and €200): €							
Net annual salary ^{1,2} : € • Deferred period: ○ 30 days ○ 60 days							
Is the principal insured in a business start-up situation? YES NO							
► Annual premium (all taxes included): €							
Please attach a conv of your most recent Notice of Assessment and payslin							

	CHOICE OF BENEFITS AND LEVELS OF COVER (CONTINUED)							
4	Spouse Net annual salary ^{1,2} : € Net annual salary ^{1,2} : € • Amount of daily benefit requested (between €20 and €200): € • Deferred period: ○ 30 days ○ 60 days Is the spouse in a business start-up situation? ○ YES ○ NO							
	► Annual premium (all taxes included): €							
5	Choice of effective date: / 2017 (1st or 16th of the month only) (subject to your application being approved and at the earliest on the 16th of the month or the first day of the month following receipt of the Application form)							
	Calculating and paying the premium							
			Tick your chosen pa	yment method:				
	SELECT THE PAYMENT FREQUENCY:	SEPA direct debit from a bank account in Euros (accepted countries: France, Monaco and Germany)	Credit or debit card	Bank transfer	Cheque			
	Annually	0	0	0	0			
	Twice yearly	0						
	Quarterly	0	€23 per quarter or €92 per year					
	Monthly	0						
	Annual membership fee of the to selected benefits: Annual management fee in ad	e Association des Assurés d'APRI dition to selected benefits:	IL International in addition	+ + + +	€ 2 8 0 0 0 €			
6		on 1 st January each year dependin	g on the claims history of th					
	Total amount of first premiu	m:		€				
	If you want your policy to take pro rata amount of the annu-	e effect on the 16 th of the month, al premium which is valid from to account the payment frequency	the effective date of you		•			
	Paying the first premium: by cheque payable to APRIL International Expat or bank transfer. by credit or debit card (Eurocard-Mastercard and Visa only).							
	Please provide your card de	etails using the box on page 19						
	payments when they are du	or credit/debit card. For these thue. e send us your bank details and fill			sponsibility to make the			
	Paperless premium notices are tick the following box:	e available by e-mail or in your or	nline Customer zone. If you	ı would also like to receive	a paper version, please			

SIGNING THE APPLICATION

I hereby apply for membership of the Association des Assurés d'APRIL International under their agreements with Axéria Prévoyance for medical expenses, death and total and irreversible loss of autonomy and income protection cover (plan numbers A3MECFDS2010 and A3MECPREV2010) and CHUBB for repatriation assistance cover (plan number FRBBBAO1855), for the insured members listed on the Application form. I have read the Association's statutes and regulations (available to download at http://en.april-international.com/global/april-international-expat/association-of-april-international-insured).

By choosing personal liability (private capacity) and legal assistance cover, I am applying for insurance with CHUBB (policy number FRBOPA10174) and Solucia PJ (policy number 10006606) under this policy.

I have read the General conditions EU Cov outlining the details of my insurance cover. I am aware of my right to cancel the insurance and accept the terms and conditions. I have retained a copy of these. I also understand the terms and conditions of APRIL International Expat's handling of my insurance cover. If my insurance cover is subsequently amended, I accept that the General conditions applied will be those outlined above.

APRIL International Expat may contact me by telephone regarding my application for insurance unless I opt out by sending an email to: adhesion.expat @april-international.com or by post to the above address.

In application of Article L121-34 of the French Consumer Code, I have the right to opt out of marketing calls and can exercise this right by contacting Opposetel at: http://www.bloctel.gouv.com

I have been informed that the information requested is required in order to process my application and that these details will be held electronically by APRIL International Expat, the insurers or their agents for the requirements of my insurance cover.

Under the French Act of 6th January 1978 (amended), I have the right to access and, if necessary, rectify any personal information held on file by writing to APRIL International Expat, 110 avenue de la République, CS 51108, 75127 Paris Cedex 11, FRANCE.

I also have the right to set quidelines in respect of the retention, deletion and disclosure of my details after my death.

In the absence of any guidelines, my rights will lapse on my death but my heirs may nevertheless:

- access the processing of my personal information in order to identify and retrieve information to be used for the disposition and distribution of my estate and also to retrieve digital assets or information representing family souvenirs which may be passed on to the heirs;
- have my death recorded and consequently close my user accounts, prevent the continued processing of my personal information or have it updated.

I may exercise this right by sending a letter together with a double-sided copy of an identity document to the above address.

APRIL International Expat has the right to use certain administrative information and to share it with APRIL subsidiaries, who may use it to make me aware of new products or services.

Under the French Act of 6th January 1978 (amended), I have the right to prevent my details being passed on in this way by writing to APRIL International Expat at the above address. Postal charges will be refunded.

Furthermore, in order to meet its legal obligations, APRIL International Expat is implementing a monitoring procedure the purpose of which is to combat money laundering and the financing of terrorism, and the application of financial penalties. In accordance with article L561-45 of the French Monetary and Financial Code, I can exercise my right of access by applying to the French Data Protection Agency, Commission Nationale Informatique et Libertés - 8, rue Vivienne - CS 30223 - 75083 Paris Cedex 02 - FRANCE. However, if the request is in connection with the procedure introduced for the purpose of identifying persons whose assets have been frozen or on whom a financial penalty has been imposed under the French Data Protection Act 78-17 of 6th January 1978, I can exercise my right of access by sending a letter, together with a copy of my ID, to APRIL International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Retention of information - my information is stored for the applicable limitation periods.

I understand that telephone calls to APRIL International Expat may be recorded for administrative purposes and that I may have access to recordings made of my calls by writing to APRIL International Expat at the above address. I understand that each recording is kept for a maximum of 2 months.

I declare either that I am not insured under the statutory healthcare scheme of my host country or that my contributions to that scheme are up to date.

I understand that cover under the present policy does not exempt me from paying contributions to any state scheme to which I may belong.

I accept that the reimbursement of or compensation for expenses incurred as a result of illness, maternity or an accident cannot exceed the amounts which were invoiced to me. I understand that APRIL International Expat requires me to declare any similar insurance cover which I may have purchased from other insurers.

I understand that the insurers will not cover any costs deemed to be unreasonable and unusual considering the location in which they were incurred.

I authorise APRIL International Expat and my treating doctors to exchange any information, including medical details, required for the management of my claims.

I understand that the pre-contractual and contractual relations for this policy are governed by French law and the French language.

I, the undersigned, certify that I have answered all the questions accurately and honestly and have neither included or omitted anything which might mislead the insurers. I have been informed that any non-disclosure or misrepresentation will result in the application of the sanctions provided under articles L113-8 and L113-9 of the French Insurance Code.

I would like to receive offers from APRIL's partners by email.	
Signed in (town or city)	Date d d m m y y y y
Signature(s) of the principal insured and insured spouse preceded by the words "I have read, understood and accepted the policy document":	Signature of the member (if different from the insured) preceded by the words "I have read, understood and accepted the policy document":

To insure children under 18, the member must sign the Application form and be a parent, legal guardian or person exercising parental authority.

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This Health questionnaire is valid for 6 months.

For example, if you want your policy to start on 01/07/2017, you can sign the questionnaire between 01/01/2017 and 30/06/2017. Each insured person must complete a Health questionnaire. Questions 1a), 1b) and 14 are not required for minor children.

If the policy covers more than 2 people, please photocopy the questionnaire.

For membership over the age of 60, a medical visit at your own expense is compulsory and a medical report provided by APRIL International Expat must be completed.

You must personally answer all the questions as accurately as possible as your responses are binding. This Health questionnaire is essential to the evaluation of the risk that the insurer proposes to undertake. Any unanswered questions will result in further enquiries.

Any medical information you provide is held in strict confidence. Detailed answers will help us process your application promptly.

The Medical Examiner reserves the right to ask the doctors having treated you to confirm the validity and comprehensiveness of the information provided in the Health questionnaire and to ensure that the conditions being treated do not contradict or are not inconsistent with the information provided when the insurance was purchased. This request may be made at any time, including prior to the processing of a claim or the issuing of a guarantee of payment to hospital.

If you wish your answers to remain confidential, detach this blank Health questionnaire, fill it out and send it to us enclosing all the supporting documentation required in a sealed envelope with the word "Confidential" for the attention of the Medical Examiner to the following address: APRIL International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Some of the medical information you provide may be processed electronically for the use of the APRIL International Expat's Medical Examiner. Under the French Act of 6th January 1978 (amended), you have the right to access and, if necessary, rectify any personal information held on file by writing to the APRIL International Expat's Medical Examiner at the above address.

	SURNAME: FIRST NAME(S):								
	DATE OF BIRTH:	HEIGHT: L cr	m WEIGHT: kg						
	a) Are you currently on total or partial sick leave from work?	○ YES ○ NO	Reason:						
1	b) During the last 10 years , have you had any periods of total or partial sick leave from work lasting more than 15 days?	○ YES ○ NO	Reason: Start date: L						
	c) Do you have a recognised infirmity or total or partial disability/incapacity?	○ YES ○ NO	Please specify: Start date: Origin or cause: Percentage of permanent incapacity or disability: %						
2	Do you have a congenital or hereditary disorder?	○ YES ○ NO	Illness:						
3	Have you ever had an accident which caused aftereffects?	○ YES ○ NO	Date of accident: Location of after-effects: Nature of after-effects:						
	a) Are you currently having any medical or paramedical treatment (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Duration of treatment:						
4	b) During the last 5 years, have you had any medical or paramedical treatment (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment) lasting more than 15 days?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Duration of treatment:						

5	During the last 10 years, have you been admitted to a medical facility, including for periods of less than 24 hours, (clinic, hospital, care home, psychiatric unit) for: - an operation or medical or surgical procedure (endoscopy, biopsy, arthroscopy, angioplasty), - specialist examinations and tests, - treatment, - convalescence, - addiction treatment, - rehabilitation, excluding surgery on wisdom teeth, tonsils and adenoids and for appendicitis?	○ YES ○ NO	Date: L Reason for admission: Length of stay: Results: Prescribed treatment:
6	During the last 5 years, have you had any laboratory tests (blood, urine or stools), cardiology tests (ultrasound, ECG, Doppler, Holter) and/or medical imaging (ultrasound, scans, PET scans, scintigraphy, MRI, endoscopy, colonoscopy, gastroscopy, radiology or mammogram)?	○ YES ○ NO	Date: Type of test: Reason for test: Results : Prescribed treatment:
7	Over the last 12 months, have you had your blood pressure checked by a doctor?	○ YES ○ NO	If yes, what were the results?
	Do you currently suffer or have you suffered over the last	t 10 years from the fo	llowing types of illness:
	a) Respiratory (asthma, chronic bronchitis, tuberculosis, respiratory failure or any other respiratory disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:
	b) Cardiovascular (high blood pressure, phlebitis, heart attack, stroke or any other cardiovascular disorders)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:
8	c) Ophthalmic/ENT (glaucoma, cataract, blindness (even if in one eye), deafness or any other eye or ENT disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:
	d) Articular (cervicalgia, slipped disc, sciatica, lumbago, polyarthritis or any other disorder of the bones or joints or autoimmune diseases)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:
	e) Dermatological (eczema, psoriasis, lupus or any other dermatological condition)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:
	f) Digestive (Crohn's disease, ulcerative colitis, oesophageal varices, liver disease, pancreatic disease or any other digestive disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:



Do you currently suffer or have you suffered over the last 10 years from the following types of illness:						
	g) Neuromuscular (epilepsy, myopathy, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia or any other disorder of the nervous or muscular system)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:			
	h) Metabolic and endocrine (thyroid, diabetes, cholesterol, pituitary disease or any other disorder of the metabolic or endocrine system)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:			
	i) Urinary and renal (kidney disease, urinary tract disease or any other disorders of the urinary and renal system)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:			
8	j) Genital (endometriosis, prostate disease or any other gynecological or urogenital disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:			
	k) Nervous (depression, stress, anxiety, neuroses, psychoses, fibromyalgia, eating disorders or any other psychological or psychiatric disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:			
	Tumour/Cancer (leukemia, Hodgkin's disease, lymphoma, benign and/or malignant tumours or any other cancerous disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:			
	m) Other infectious, viral, parasitic or haematological diseases, malaria, hepatitis or disorders requiring medical supervision?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:			
9	Have you been screened for hepatitis B and C or the human immunodeficiency virus (HIV), where the result was positive?	○ YES ○ NO	Virus: Date of test: (you only need to answer YES to this question if the result of one of the tests was positive)			
10	Are you being monitored by a specialist?	○ YES ○ NO	Reason: Start date of the illness: Treatment(s):			
11	In the last six months, have you had any diagnostic tests (lab tests, medical imaging) or additional medical examinations?	○ YES ○ NO	Reason: Type of examination or tests: Date:			
12	Is it planned over the next 6 months for you to have any medical tests (lab tests, medical imaging, endoscopy or any other medical test), consult a medical specialist or undergo any medical or surgical treatment?	O YES O NO	Reason: Date of scheduled tests: Nature of scheduled tests: Date of planned treatment: Type of planned treatment: Length of planned treatment: Specialty of the doctor consulted:			



13	Is it planned within 12 months of the effective date of your insurance policy for you to be admitted to hospital , including as an outpatient (knee surgery, removal of cyst, childbirth or for any other reason)?	○ YES ○ NO	Reason: Scheduled date: L.						
14	In the last 5 years have you been accepted for insurance subject to exclusions or additional premiums, or had cover denied or cancelled by the insurer of a healthcare or death & disability insurance policy (daily sick leave allowance, disability, death)?	○ YES ○ NO	Reason for cancellation, additional premium or denial of cover:						
	Details if you answered YES to any of the questions: To help us process your application, you can provide additional details about your health condition.								
AD	ADDITIONAL INFORMATION								
THE	INSURERS' MEDICAL EXAMINERS RESERVE THE RIG	GHT TO REQUEST FU	JRTHER MEDICAL EXAMINATIONS.						
risk	non-disclosure, intentional misrepresentation or inacc will result in the cancellation of all cover under the poli French Insurance Code).								
	eby certify that I have answered all the questions accurately nsurers of the present policy.	and honestly and ha	ve neither included or omitted anything which might mislead						
Sign	ed in (town or city)		Date d d / m m / y y y y						
"	nature of the insured preceded by the words "I have read, understo- nature of the father, mother or legal guardian for insured children und		licy document":						

2

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You must personally answer all the questions as accurately as possible as your responses are binding. This Health questionnaire is essential to the evaluation of the risk that the insurer proposes to undertake. Any unanswered questions will result in further enquiries.

Any medical information you provide is held in strict confidence. Detailed answers will help us process your application promptly.

The Medical Examiner reserves the right to ask the doctors having treated you to confirm the validity and comprehensiveness of the information provided in the Health questionnaire and to ensure that the conditions being treated do not contradict or are not inconsistent with the information provided when the insurance was purchased. This request may be made at any time, including prior to the processing of a claim or the issuing of a guarantee of payment to hospital.

If you wish your answers to remain confidential, detach this blank Health questionnaire, fill it out and send it to us enclosing all the supporting documentation required in a sealed envelope with the word "Confidential" for the attention of the Medical Examiner to the following address: APRIL International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Some of the medical information you provide may be processed electronically for the use of the APRIL International Expat's Medical Examiner. Under the French Act of 6th January 1978 (amended), you have the right to access and, if necessary, rectify any personal information held on file by writing to the APRIL International Expat's Medical Examiner at the above address.

	SURNAME: FIRST NAME(S):									
	DATE OF BIRTH:	HEIGHT: L cr	m WEIGHT: L, , L kg							
	a) Are you currently on total or partial sick leave from work?	○ YES ○ NO	Reason: Start date:							
1	b) During the last 10 years , have you had any periods of total or partial sick leave from work lasting more than 15 days?	○ YES ○ NO	Reason: Start date: L End date: L							
	c) Do you have a recognised infirmity or total or partial disability/incapacity?	○ YES ○ NO	Please specify: Start date: Origin or cause: Percentage of permanent incapacity or disability: %							
2	Do you have a congenital or hereditary disorder?	○ YES ○ NO	Illness: Treatment and/or follow-up: Date of diagnosis:							
3	Have you ever had an accident which caused aftereffects?	○ YES ○ NO	Date of accident: Location of after-effects: Nature of after-effects:							
	a) Are you currently having any medical or paramedical treatment (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Duration of treatment:							
4	b) During the last 5 years, have you had any medical or paramedical treatment (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment) lasting more than 15 days?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Duration of treatment:							

5	During the last 10 years, have you been admitted to a medical facility, including for periods of less than 24 hours, (clinic, hospital, care home, psychiatric unit) for: - an operation or medical or surgical procedure (endoscopy, biopsy, arthroscopy, angioplasty), - specialist examinations and tests, - treatment, - convalescence, - addiction treatment, - rehabilitation, excluding surgery on wisdom teeth, tonsils and adenoids and for appendicitis?	○ YES ○ NO	Date: Reason for admission: Length of stay: Results: Prescribed treatment:		
6	During the last 5 years, have you had any laboratory tests (blood, urine or stools), cardiology tests (ultrasound, ECG, Doppler, Holter) and/or medical imaging (ultrasound, scans, PET scans, scintigraphy, MRI, endoscopy, colonoscopy, gastroscopy, radiology or mammogram)?	○ YES ○ NO	Date: Type of test: Reason for test: Results : Prescribed treatment:		
7	Over the last 12 months, have you had your blood pressure checked by a doctor?	○ YES ○ NO	If yes, what were the results?		
	Do you currently suffer or have you suffered over the last	Do you currently suffer or have you suffered over the last 10 years from the following types of illness:			
8	a) Respiratory (asthma, chronic bronchitis, tuberculosis, respiratory failure or any other respiratory disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:		
	b) Cardiovascular (high blood pressure, phlebitis, heart attack, stroke or any other cardiovascular disorders)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:		
	c) Ophthalmic/ENT (glaucoma, cataract, blindness (even if in one eye), deafness or any other eye or ENT disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:		
	d) Articular (cervicalgia, slipped disc, sciatica, lumbago, polyarthritis or any other disorder of the bones or joints or autoimmune diseases)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:		
	e) Dermatological (eczema, psoriasis, lupus or any other dermatological condition)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:		
	f) Digestive (Crohn's disease, ulcerative colitis, oesophageal varices, liver disease, pancreatic disease or any other digestive disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:		

Do you currently suffer or have you suffered over the last 10 years from the following types of illness:		llowing types of illness:		
8	g) Neuromuscular (epilepsy, myopathy, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia or any other disorder of the nervous or muscular system)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:	
	h) Metabolic and endocrine (thyroid, diabetes, cholesterol, pituitary disease or any other disorder of the metabolic or endocrine system)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:	
	i) Urinary and renal (kidney disease, urinary tract disease or any other disorders of the urinary and renal system)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:	
	j) Genital (endometriosis, prostate disease or any other gynecological or urogenital disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:	
	k) Nervous (depression, stress, anxiety, neuroses, psychoses, fibromyalgia, eating disorders or any other psychological or psychiatric disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:	
	Tumour/Cancer (leukemia, Hodgkin's disease, lymphoma, benign and/or malignant tumours or any other cancerous disorder)?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:	
	m) Other infectious, viral, parasitic or haematological diseases, malaria, hepatitis or disorders requiring medical supervision?	○ YES ○ NO	Illness(es): Treatment(s): Start of treatment: Length of treatment: Results of treatment:	
9	Have you been screened for hepatitis B and C or the human immunodeficiency virus (HIV), where the result was positive?	○ YES ○ NO	Virus: Date of test:	
10	Are you being monitored by a specialist?	○ YES ○ NO	Reason: Start date of the illness: Treatment(s):	
11	In the last six months, have you had any diagnostic tests (lab tests, medical imaging) or additional medical examinations?	○ YES ○ NO	Reason: Type of examination or tests: Date: Results:	
12	Is it planned over the next 6 months for you to have any medical tests (lab tests, medical imaging, endoscopy or any other medical test), consult a medical specialist or undergo any medical or surgical treatment?	○ YES ○ NO	Reason: Date of scheduled tests: Nature of scheduled tests: Date of planned treatment: Type of planned treatment: Length of planned treatment: Specialty of the doctor consulted:	



13	Is it planned within 12 months of the effective date of your insurance policy for you to be admitted to hospital, including as an outpatient (knee surgery, removal of cyst, childbirth or for any other reason)?	YES NO	Reason: Scheduled date: Lund Length of stay:
14	In the last 5 years have you been accepted for insurance subject to exclusions or additional premiums, or had cover denied or cancelled by the insurer of a healthcare or death & disability insurance policy (daily sick leave allowance, disability, death)?	○ YES ○ NO	Reason for cancellation, additional premium or denial of cover:
	ails if you answered YES to any of the questions: elp us process your application, you can provide additional	details about your he	ealth condition.
AE	DITIONAL INFORMATION		
Any risk	INSURERS' MEDICAL EXAMINERS RESERVE THE RIG non-disclosure, intentional misrepresentation or inacci will result in the cancellation of all cover under the poli French Insurance Code).	uracy altering the na	ature of the risk or influencing the insurers to reduce the
l he	reby certify that I have answered all the questions accurately insurers of the present policy.	and honestly and ha	ve neither included or omitted anything which might mislead
Sigr	ned in (town or city)		Date d d / m m / y y y y
1 .	nature of the insured preceded by the words "I have read, underston produced in the father, mother or legal guardian for insured children underston the father, mother or legal guardian for insured children underston the father, mother or legal guardian for insured children understoned in the father.		plicy document":

YOUR APPLICATION STEP BY STEP:



Fill in your Application form and send it to APRIL International Expat.

If you need help, read the tips on the last page or contact us.



Your application is processed on receipt.



You will be sent:

- your Membership certificate serving as your insurance certificate,
 - the General conditions showing how your policy operates,
- your insurance card containing emergency contact numbers for requesting assistance services or before admission to hospital,
- a Guide to your insurance cover, giving an overview of how your policy works and all the useful contact details.











SEPA DIRECT DEBIT MANDATE

(to be completed if selecting payment by direct debit)
Unique Mandate Reference (to be completed by the creditor):
By signing this mandate form, you authorise (A) APRIL International Expat to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from APRIL International Expat.
You have the right to a refund from your bank under the terms and conditions of your agreement with your bank. A refund mus be claimed within 8 weeks starting from the date on which your account was debited.
Please complete the fields marked *
ACCOUNT HOLDER:
Debtor's surname*:
Debtor's first name(s)*:
Debtor's address*:
Postcode*: Town or city*:
Country*:
Bank account to be debited*:
IBAN:
BIC:
Type of payment* (tick where appropriate): Recurring payment One-off payment
CREDITOR:
APRIL International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE SEPA creditor identification number: FR54ZZZ004082
Signed in (town or city)*: Date*: Signature*:
NB: Details of your rights with respect to this mandate are available from your bank. The information contained in this mandate will be processed electronically by APRIL International Expat in order to manage your direct debit payments and will be sent only to your bank for this purpose. Under the French Data Protection and Freedom of Information Act of 6th January 1978, amended in 2004, you have the light to access and query your personal information and have this information corrected or deleted. You can exercise this right by writing to the Customer Service department at APRIL International Expat.

Creditor's use only

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Please return this form to APRIL International Expat enclosing a copy of your bank account details.

To cancel your policy, please use the tear-off slip below and send it to: APRIL International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

CANCELLATION

Article L.112-9 of the French Insurance Code

Any person who is canvassed at their home or residence or place of work, or by means of distance communication such as telephone or internet, even at their own request, and who signs an insurance proposal or contract for a purpose which is not related to their commercial or professional activity, may cancel this agreement by sending a letter by recorded delivery with proof of receipt during a period of 14 days from the day of signature of the agreement without requiring to specify the reason for the cancellation or being subject to penalties.

Conditions: If you wish to cancel your insurance policy, please fill in and sign this tear-off slip. You should then send it in a sealed envelope by registered letter with proof of receipt to the above address. It must be sent no later than 14 days on the day following signature of your application or, where the deadline expires on a Saturday, Sunday or a bank holiday or other non-working day, on the next working day.

I, the undersigned, wish to cancel my application for insurance under the following policy:

Policy name: Euro Cover+ Ref. EU Cov						
Date of signature of Application form:						
Member's surname:						
Member's first name:						
Member's address:						
Postcode:	City:					
Country:						
Telephone:						
Name of insurance consultant:						
Address of insurance consultan	nt:					
Postcode:	City:					
Country:						
Telephone:						
Date and member's signature:						
Reserved f	for APRIL International Expat: Client reference number					





TAKING OUT THE INSURANCE

- A. Fill in your personal details 1, 2 and 3.
- B. Select your level of cover 4.
- C. Indicate the date on which you want your cover to take effect 5.
- D. Calculate your premium and indicate your selected payment method 6.
- E. Date and sign your application in part 7.
- F. Date, complete and sign the Health questionnaire(s) 8.
- G. For the payment of your first premium, you can:
 - enclose a cheque payable to APRIL International Expat, OR
 - provide your credit/debit card details at page 19 of the Application form, OR
 - arrange for a bank transfer (in this case, attach a copy of the transfer order).
 - For the following premiums, please fill in the SEPA direct debit mandate if you wish to make payments by direct debit from a bank account in Euros (accepted countries: France, Monaco and Germany).
- H. If you wish to request a waiver of the waiting periods, that apply to the medical expenses cover please enclose the Exit certificate from your previous policy with details of your cover.
- I. Depending on the benefits that you have selected, please enclose with the Application form the following additional documents:
 - for death and total and irreversible loss of autonomy cover: a copy of your identity card (national identity card or passport),
 - for income protection benefits: a copy of your most recent Notice of Assessment and payslip.

Send your application form and supporting documents to APRIL International Expat - Service Adhésions Individuelles 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

WHAT HAPPENS NEXT?

Your application is processed as soon as we receive your Application form and supporting documents.

Your insurance is evidenced by a Membership certificate (serving as insurance certificate) showing details of the cover you have elected and the effective date of your policy.

Your policy will start on the date shown on the Membership certificate and, at the earliest, on the 16th of the month or the first day of the month following receipt of your Application form and supporting documents.

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Headquarters:

110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

Tel.: +33 (0)173 02 93 93 - Fax: +33 (0)173 02 93 90

Email: info.expat@april-international.com - www.april-international.com

A French simplified joint-stock company (S.A.S.) with capital of €200 000
Registered with Companies House in Paris under number 309 707 727 - Insurance broker
Registered with ORIAS (Organisation for the registration of insurance brokers) under number 07 008 000 (www.orias.fr)
Autorité de Contrôle Prudentiel et de Résolution (Prudential Supervision and Resolution Authority)
61, rue Taitbout -75436 Paris Cedex 09 - FRANCE
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