APPLICATION FORM
2017

MAGELLAN

KOMPARO ASSURANCES

april international

MAGELLAN APPLICATION FORM

Insurance consultant reference number: I81897

Are you already customer at APRIL International Expat? ◯ YES ◯ NO If yes, please indicate your Customer Number: C

PLEASE WRITE IN CAPITAL LETTERS

INSURED Person(s) to be insured

If you have more than 2 dependent children, please photocopy page 2 and fill it out.

Title of **principal insured**: Mrs ◯ Mr ◯

Surname of **principal insured**:

First names of **principal insured**:

Date of birth: d d / m m / y y y y *(max. 74 years)*

Country of nationality:

Country of destination:

Occupation (detailed):

Business sector:

Status of **principal insured**: Student ◯ Employee ◯ Self-employed ◯ Language course ◯

Working holiday programme (WHP) ◯ Other: .....

E-mail:

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Title of **spouse**: Mrs ◯ Mr ◯

Surname of **spouse**:

First names of **spouse**:

Date of birth: d d / m m / y y y y *(min. 18 years, max. 74 years)*

Country of nationality:

Country of destination:

Occupation (detailed):

Business sector:

Status of **spouse**: Student ◯ Employee ◯ Self-employed ◯ Language course ◯

Working holiday programme (WHP) ◯ Other: .....

Surname of **1st dependent child**:

First names of **1st dependent child**:

Date of birth: d d / m m / y y y y Sex: Male ◯ Female ◯

Surname of **2nd dependent child**:

First names of **2nd dependent child**:

Date of birth: d d / m m / y y y y Sex: Male ◯ Female ◯

PRINCIPAL INSURED — Address for delivery of correspondence

If you go to the United States please give us your exact local address so that we can send you your third party pharmacy card.

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Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: +

Mobile: +

Any correspondence from us (your insurance certificate, General conditions, reimbursement statements etc.) will be sent by e-mail. If you would also like to receive a paper version, please tick this box: ◯
Your insurance card will be sent by post.

I would like to receive my correspondence in: English ◯ French ◯ Spanish ◯ German ◯

MEMBER = WHO IS PAYING THE PREMIUM

◯ **The principal insured is paying the premium** (in this case, the address below is not required)
◯ **The person paying the premium is not the principal insured**

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Individual ◯ **Corporate** ◯ Name of company:

Title: Mrs ◯ Mr ◯

Surname:

First names:

Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: +

Mobile: +

E-mail:

I would like to receive my correspondence in: English ◯ French ◯ Spanish ◯ German ◯

DURATION AND LEVEL OF COVER

Period of cover required: from d d / m m / y y y y to d d / m m / y y y y , i.e. . months

Type of cover selected:

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◯ **Complete option with reimbursements from the 1st euro spent**

◯ **Mini option with reimbursements from the 1st euro spent**

Type of membership:

→ ◯ individual

→ ◯ couple

→ ◯ principal insured + ☐ child(ren)

→ ◯ family (the level of the family premium depends on the age of the eldest person)

FOR MEDICAL EXPENSES, YOU CAN BE REIMBURSED BY:

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- ◯ cheque in euro.
- ◯ bank transfer to a bank account in France. In this case, please send us details of your bank account.
- ◯ bank transfer to an account in the USA. International bank details are required including the IBAN number, SWIFT code, your bank's address, sort code and an ABA routing number.
- ◯ bank transfer to an account in other countries. International bank details are required including your bank account number, SWIFT code, your bank's address.

Depending the location of your bank account, bank charges may apply to your reimbursement.

BENEFICIARIES IN THE EVENT OF DEATH FOR PERSONAL ACCIDENT BENEFIT

If you have more than 2 legally adult dependent children, please photocopy page 4 and fill it out.

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):

.....

.....

.....

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1st legally adult dependent child: 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):

.....

.....

.....

2nd legally adult dependent child: 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):

.....

.....

.....

In the absence of a precise designation of the beneficiaries, the death benefit shall be transferred to the surviving spouse on condition that they were not legally separated when the lump sum became payable; second, equally, to their children living, to be born or represented as such; third, equally to their ascendants and fourth to their other heirs.

The beneficiaries in the event of the death of the insured's minor dependent children are: first the principal insured, second their spouse and third their other children in equal parts.

CALCULATING THE PREMIUM

Minimum period of cover: 15 days; maximum 12 months.

Calculating the premium

Taking into account the age bracket, the type of membership, the level of cover and the payment method (full payment or monthly instalments), please refer to page 9 of the brochure to calculate the amount of the premium.

→ If the policy covers **one individual, 2 individuals,** or **an individual and their children,** the total amount of the premium is the sum of all the **individual premiums**.

- Premium principal insured: €☐☐☐☐
- Premium spouse: +€☐☐☐☐
- Premium child(ren): (€☐☐☐☐ X ☐ child(ren)): +€☐☐☐☐
- Instalment charges for monthly payment (€6 X ☐☐ months): +€☐☐☐☐

  (monthly payment is possible if your contract doesn't include a half month)

- **Total premium (all taxes included):** =€☐☐☐☐

→ If the policy covers a **family** (2 adults and 1 or several child[ren]) the amount of the premium is the **family premium**.

- Family premium: €☐☐☐☐
- Instalment charges for monthly payment (€6 X ☐☐ months): +€☐☐☐☐

  (monthly payment is possible if your contract doesn't include a half month)

- **Total premium (all taxes included):** =€☐☐☐☐

SELECTING THE PAYMENT METHOD

◯ **Full payment at the time of application by:**

- ◯ **cheque,** payable to **APRIL International Expat**
- ◯ **credit/debit card** (only Eurocard-Mastercard and Visa are accepted)

Please provide your card details using the box on page 13.

◯ **Payment in monthly instalments** (by SEPA direct debit from a bank account in France, Monaco or Germany)

Please send us your bank details and fill in the attached SEPA direct debit authorisation form.

You wish to pay the first premium by:

- ◯ **credit/debit card** (please provide your card details using the box on page 13)
- ◯ **cheque** (please make it payable to **APRIL International Expat**)

SIGNING THE APPLICATION

I hereby apply for membership of the Association des Assurés d'APRIL International under their agreements with Groupama Gan Vie for medical expenses (plan number 219/851 724) and CHUBB for repatriation assistance cover (plan number FRBBBA05125), 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 internships), personal accident, baggage and legal assistance cover, I am applying for insurance with CHUBB (policy number FRBOPA10170) and Solucia PJ (policy number 10006604) under this policy.

I have read the General conditions Ma 2017 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.

SIGNING THE APPLICATION (CONTINUED)

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

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.fr

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 guidelines 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 utilise certain administrative information and to share it with APRIL subsidiaries who may use it to make me aware of new products or services. A list of these companies is available on request.

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 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.

9 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 understand that cover under the present policy does not exempt me from paying contributions to any state scheme to which I may belong and that some benefits are subject to the application of waiting periods.

I accept that the reimbursement of or compensation for expenses incurred as a result of illness 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 principal insured) preceded by the words "**I have read, understood and accepted the policy document**":

Your Insurance consultant stamp + APRIL International Expat Code:

FREV KOMPARO ASSURANCES
8, Rue Guy Pellerin
33114 LE BARP
✆: +33 (0)5 35 54 40 82
✉: info@komparo.fr
💻: www.komparo.fr
I81897

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

HEALTH QUESTIONNAIRE

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.
If the policy covers more than 4 people, please photocopy the questionnaire.

IF YOU **OR** YOUR SPOUSE ARE UNDER 30 YEARS OF AGE, PLEASE ANSWER ONLY QUESTIONS 1, 6 AND 10

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 a 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.

QUESTIONS:	PRINCIPAL INSURED	SPOUSE	1ST DEPENDENT CHILD	2ND DEPENDENT CHILD
1 Height:	⌊_⌋ cm	⌊_⌋ cm	⌊_⌋ cm	⌊_⌋ cm
1 Bis Weight:	⌊_⌋ kg	⌊_⌋ kg	⌊_⌋ kg	⌊_⌋ kg
2 Are you currently on partial or total sick leave from work due to illness or accident?	◯ YES ◯ NO	◯ YES ◯ NO		
3 Within the **last 10 years**, have you:				
a) undergone surgery?	◯ YES ◯ NO	◯ YES ◯ NO		
b) undergone laser treatment, chemotherapy or radiation therapy?	◯ YES ◯ NO	◯ YES ◯ NO		
4 Within the **last 5 years**, have you had an illness or an accident which resulted in:				
a) more than one month's sick leave from work?	◯ YES ◯ NO	◯ YES ◯ NO		
b) more than one month's medical treatment?	◯ YES ◯ NO	◯ YES ◯ NO		
5 Within the **last 5 years**, have you consulted a doctor for:				
a) nervous conditions (chronic fatigue, anxiety, depression)?	◯ YES ◯ NO	◯ YES ◯ NO		
b) back complaints (back pain, sciatica, slipped disc)?	◯ YES ◯ NO	◯ YES ◯ NO		
c) arthritis and/or rheumatism (hip, knee, shoulder, etc.)?	◯ YES ◯ NO	◯ YES ◯ NO		
6 Do you suffer from any disorder or illness requiring or not regular medical supervision or treatment?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
7 Have you been tested for HBV (Hepatitis B)?	◯ YES ◯ NO	◯ YES ◯ NO		
If you answered **YES** to this question, were the results positive?	◯ YES ◯ NO	◯ YES ◯ NO		
Date of the test (DD/MM/YYYY):	⌊_⌋	⌊_⌋		
7 Bis Have you been tested for HCV (Hepatitis C)?	◯ YES ◯ NO	◯ YES ◯ NO		
If you answered **YES** to this question, were the results positive?	◯ YES ◯ NO	◯ YES ◯ NO		
Date of the test (DD/MM/YYYY):	⌊_⌋	⌊_⌋		

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HEALTH QUESTIONNAIRE (CONTINUED)

QUESTIONS (CONTINUED):	PRINCIPAL INSURED	SPOUSE	1ST DEPENDENT CHILD	2ND DEPENDENT CHILD
7 Ter Have you been tested for HIV (AIDS)?	◯ YES ◯ NO	◯ YES ◯ NO		
If you answered **YES** to this question, were the results positive?	◯ YES ◯ NO	◯ YES ◯ NO		
Date of the test (DD/MM/YYYY):				
8 Do you have a disability or a handicap, or a disability which entitles you to benefits?	◯ YES ◯ NO	◯ YES ◯ NO		
9 Will you undergo any diagnostic test **over the next 6 months** (lab tests, scans, endoscopy, etc.) and/or have a consultation with a specialist and/or any treatment or surgery?	◯ YES ◯ NO	◯ YES ◯ NO		
10 Is it planned for you to be hospitalised for any reason whatsoever **during the 12 months following the effective date of your insurance cover** (removal of tonsils, knee surgery, removal of cyst, childbirth, etc.)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
11 Within the last **12 months**, have you had:				
a) more than 3 periods of sick leave of any duration?	◯ YES ◯ NO	◯ YES ◯ NO		
b) specialist tests (other than routine screening) such as lab tests, scans, endoscopy, etc.?	◯ YES ◯ NO	◯ YES ◯ NO		

Further details if the response to one of the questions is YES:

To help us process your application, please provide further details regarding the events surrounding the illness or accident and any consequences resulting from it.

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Example:

If you have had an operation to remove your appendix and answered YES to question 3, you would write in the space below: *2, appendix removed, 2010, 3 days in hospital. No further treatment required.*

ADDITIONAL INFORMATION

THE INSURER'S MEDICAL EXAMINERS RESERVE THE RIGHT TO REQUEST FURTHER MEDICAL EXAMINATIONS.

Any non-disclosure, intentional misrepresentation or inaccuracy altering the nature of the risk or influencing the insurers to reduce the risk will result in the cancellation of all cover under the policy. In such circumstances the premium will not be refunded (art. L113-8 of the French Insurance Code).

I hereby certify that I have answered all the questions accurately and honestly and have neither included or omitted anything which might mislead the insurers of the present policy.

Signed in (town or city) _____ Date d d / m m / y y y y

Signature of the principal insured preceded by the words "**Read, understood and accepted**":	Signature of the insured spouse preceded by the words "**Read, understood and accepted**":	Signature(s) of the insured dependent child(ren) over 18 preceded by the words "**Read, understood and accepted**":

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 must 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*: d d / m m / y y y y

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 right 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.

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

Creditor's use only

Please send your completed application to:

APRIL International Expat
Service Adhésions Individuelles
110, avenue de la République - CS 51108
75127 Paris Cedex 11 - FRANCE

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 from 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: **Magellan Ref. Ma 2017**

Date of signature of Application form: d d / m m / y y y y

Member's surname:

Member's first name:

Member's address:

Postcode: City:

Country:

Telephone: / / / / /

Name of insurance consultant:

Address of insurance consultant:

Postcode: City:

Country:

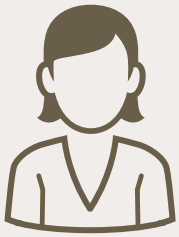
Telephone: / / / / /

Date and member's signature:

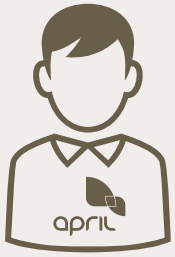
d d / m m / y y y y

Reserved for APRIL International Expat: Client reference number C

YOUR APPLICATION STEP BY STEP:



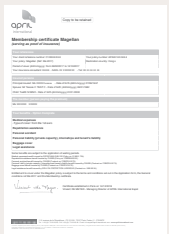
Fill in your Application form and send it to APRIL International Expat.
If you need help, read the tips on the next page or contact us.

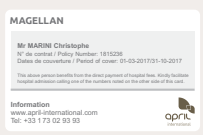


Your application is processed upon receipt.

You will then receive:

- **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.**





DATA RELATING TO PAYMENTS BY BANK CARD

If you opt for payment by card, in accordance with French Data Protection regulation No. 2013-358 of 14th November 2013, card details are stored only for the purpose of completing your transaction and will be destroyed at the end of the cooling-off period.

Type of card: ○ Eurocard-Mastercard ○ Visa

Card number: ____ / ____ / ____ / ____ Expiry date: __ / __

The last three digits of the security number printed on the reverse of your card: ___

Card owner: ____________________

TAKING OUT THE INSURANCE

A. Fill in your personal details 1, 2 and 3.

B. Choose the duration and level of your cover 4.

C. Choose the method of reimbursement of your medical expenses 5.

D. Designate a beneficiary in the event of death for personal accident cover 6.

E. Taking into account the age bracket and the type of membership, please refer to page 9 of the brochure to calculate the amount of the premium and fill it in 7.

F. Indicate the type (in full or in monthly instalments) and method of payment selected 8.

G. Date and sign your application 9.

H. Fill in, date and sign the Health questionnaire 10.

I. Enclose a cheque in € made payable to APRIL International Expat or provide details of your credit/debit card in order to pay your premium in full or to pay your first premium in case of payment in monthly instalments.

J. If you are paying in monthly instalments:
- fill in the attached SEPA direct debit authorisation form,
- attach your bank details.

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 selected 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 day following receipt of your application form and supporting documents.

april international | expat

Headquarters:
110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE
Tel.: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90
E-mail: info.expat@april-international.com - www.april-international.com

A French simplified joint-stock company (S.A.S.) with capital of €200,000 -
RCS Paris 309 707 727 Insurance intermediary - Registered with ORIAS under number 07 008 000 (www.orias.fr)
Prudential Supervision and Resolution Authority - 61, rue Taitbout - 75436 Paris Cedex 09 - FRANCE
NAF6622Z - Intra-community VAT N° FR603009707727

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