APPLICATION FORM
2017

WELCOME COVER

KOMPARO ASSURANCES

april international

WELCOME COVER 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

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 (upper age limit of 64)

Country of nationality:

Passport number of **principal insured**: (optional)

Country of destination: FRANCE

If French Overseas Departments and Regions, please specify:

Occupation (detailed) of **principal insured**:

Business sector:

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

E-mail:

Title of **spouse**: Mrs ◯ Mr ◯

Surname of **spouse**:

First names of **spouse**:

Date of birth: d d / m m / y y y y (upper age limit of 64)

Country of nationality:

Passport number of **spouse**: (optional)

Country of destination: FRANCE

If French Overseas Departments and Regions, please specify:

Occupation (detailed) of **spouse**:

Business sector:

Status of **spouse**: Student ◯ Employee ◯ Self-employed ◯ Other ◯

INSURED — Person(s) to be insured (continued)

If you have more than 3 dependent children, please photocopy page 3 and fill it out.

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 ◯

Passport number of the **1st dependent child**: (optional)

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 ◯

Passport number of the **2nd dependent child**: (optional)

Surname of **3rd dependent child**:

First names of **3rd dependent child**:

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

Passport number of the **3rd dependent child**: (optional)

PRINCIPAL INSURED — Address for delivery of correspondence

If you would like correspondence from us to be sent care of another person, please let us know the name of the official owner/occupier at that address (the name on the letter box)

Title: Mrs ◯ Mr ◯

Surname and first names:

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: ◯

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

POLICYHOLDER = 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 ◯

PERIOD OF COVER AND CALCULATING THE PREMIUM

Period of cover required:

from d d / m m / y y y y to d d / m m / y y y y

for a duration of: , months (minimum 15 days; maximum 12 months)

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- ▸ 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 lasts at least 3 months and doesn't include a half month)
- ▸ **Total premium (all taxes included):** = €

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 the IBAN number, SWIFT code, your bank's address.

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

BENEFICIARIES IN THE EVENT OF DEATH FOR PERSONAL ACCIDENT BENEFIT

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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):

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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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If your dependent adult children want to nominate a specific beneficiary (or beneficiaries) they can do so on plain paper by providing the information requested above.

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.

SELECTION OF PAYMENT METHOD

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

- ◯ **cheque,** please make your 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.

◯ **Monthly payment** by SEPA direct debit from a bank account in Euros (accepted countries: France, Monaco and 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)
- ◯ **by cheque** (please make your cheque payable to **APRIL International Expat**)

SIGNATURE OF THE APPLICATION

I hereby apply for cover under the Welcome Cover policy insured by Groupama Gan Vie for medical expenses cover (policy number 220/936 264), by CHUBB for repatriation assistance, personal accident, personal liability (private capacity and internships) and baggage insurance cover (policies number FR32022521 and FRBOPA10171) and Solucia PJ for legal assistance cover (policy number 10006608) for the insured members listed on the Application form.

I have read the General conditions Wc 2017 outlining the details of my insurance cover. I have retained a copy of these. I am aware of my right to cancel the insurance and accept the terms and conditions. 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: 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.

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.

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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 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 of the principal insured and insured spouse preceded by the words **"I have read, understood and accepted the policy document"**:	Signature of the policyholder (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 policyholder 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 this questionnaire between 01/01/2017 and 30/06/2017.
If the policy covers more than 5 people, please photocopy the questionnaire.

You must personally answer as accurately as possible as your responses are binding. This simplified 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 hospital cover note.

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.

8 QUESTIONS:	PRINCIPAL INSURED	SPOUSE	1ST DEPENDENT CHILD	2ND DEPENDENT CHILD	3RD DEPENDENT CHILD
Height:	⌊_ _ _⌋ cm	⌊_ _ _⌋ cm	⌊_ _ _⌋ cm	⌊_ _ _⌋ cm	⌊_ _ _⌋ cm
Weight:	⌊_ _ _⌋ kg	⌊_ _ _⌋ kg	⌊_ _ _⌋ kg	⌊_ _ _⌋ kg	⌊_ _ _⌋ kg
1 Do you suffer from any disorder or illness requiring or not regular medical supervision or treatment?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
2 Within the last 10 years, have you:					
- undergone surgery?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
- undergone laser treatment, chemotherapy or radiation therapy?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
- undergone more than month's medical treatment?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
3 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	◯ YES ◯ NO

HEALTH QUESTIONNAIRE (CONTINUED)

Further details if the response to one of the question 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.

ADDITIONAL INFORMATION

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THE INSURERS' 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 **"I have read, understood and accepted the policy document"**:	Signature of the insured spouse preceded by the words **"I have read, understood and accepted the policy document"**:	Signature(s) of the insured dependent child(ren) over 18 preceded by the words **"I have read, understood and accepted the policy document"** (for children under 18, signature of the father, mother or legal guardian):

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*:

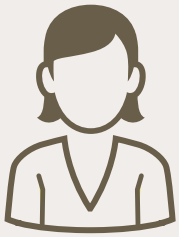
NB: Details of your rights with respect to this mandate are available from your bank.

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.

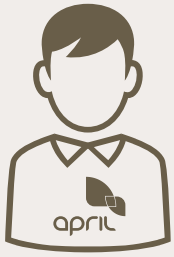
Please return this form to APRIL International Expat enclosing a copy of your bank account details.

Creditor's use only

YOUR APPLICATION STEP BY STEP:



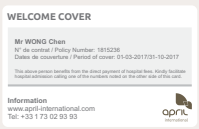
Fill in your Application form and send it to APRIL International Expat.
If you need help, read the tips on the next page or contact us.



Your application is processed on receipt.

You will be sent:

- **your Policyholder 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.**



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: **Welcome Cover Ref. Wc 2017**

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

Policyholder's surname:

Policyholder's first name:

Policyholder's address:

Postcode: City:

Country:

Telephone: / / / / /

Name of insurance consultant:

Address of insurance consultant:

Postcode: City:

Country:

Telephone: / / / / /

Date and Policyholder's signature:

d d / m m / y y y y

Reserved for APRIL International Expat: Client reference number C

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 and 2.

B. Select the duration of your policy and calculate your total premium 3.

C. Choose the method of reimbursement of your medical expenses 4.

D. For personal accident cover, please designate one or several beneficiaries in the event of death 5.

E. Indicate the type (in full or in monthly instalments) and method of payment selected 6.

F. Date and sign your application 7.

G. Date, complete and sign the Health questionnaire 8.

H. 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.

I. 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 Policyholder 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 Policyholder certificate and, at the earliest, on the day 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)1 73 02 93 93 - Fax: +33 (0)1 73 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
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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