APPLICATION FORM
2016

AMBASSADE

april international

Changing the image of insurance.

AMBASSADE APPLICATION FORM

Insurance consultant reference number: I 6 6 4 9 9

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 the insured has more than 3 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

Country of nationality:

Host country:

Occupation:

Business sector:

Are you, or any of your family members, a Politically Exposed Person*? YES ◯ NO ◯

Email:

(providing an email address will allow you to access your online Customer Zone)

1

Title of **spouse:** Mrs ◯ Mr ◯

Surname of **spouse:**

First names of **spouse:**

Date of birth: d d / m m / y y y y

Country of nationality:

Host country:

Occupation:

Business sector:

Is your spouse, or any of their family members, a Politically Exposed Person*? YES ◯ NO ◯

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 ◯

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 ◯

*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.

PRINCIPAL INSURED — ADDRESS FOR DELIVERY OF CORRESPONDENCE

2

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**

3

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

Title: Mrs ◯ Mr ◯

Surname:

First names:

Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: +

Mobile: +

Email:

(providing an email address will allow you to access your online Customer Zone)

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

CHOICE OF BENEFITS AND LEVELS OF COVER

4.1/ Medical expenses cover

Membership: ◯ individual ◯ couple ◯ principal insured + ☐ child/children
◯ family (the level of the family premium depends on the age of the eldest person)

Area of cover: ◯ zone 1 ◯ zone 2 ◯ zone 3 ◯ zone 4

Option: ◯ Essentielle ◯ Medium ◯ Extenso

Cover required: ◯ Hospitalisation only ◯ Hospitalisation **+** Routine healthcare-Maternity
◯ Hospitalisation **+** Routine healthcare-Maternity **+** Optical-Dental care

4

Level of reimbursement required*: ◯ 80% of actual costs ◯ 90% of actual costs ◯ 100% of actual costs

* Hospitalisation only cover is only available at 100% reimbursement of actual costs

▸**Annual premium (all taxes included)**: € . A

For medical expenses, you can choose to be reimbursed by:

◯ 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 account number, SWIFT code, your bank's address and an ABA routing number - to be enclosed with the Application form.

◯ bank transfer to an account in other countries. International bank details are required including the account number, SWIFT code and your bank's address - to be enclosed with the Application form.

Depending on the location of your bank account, additional fees might be charged by your bank.

CHOICE OF BENEFITS AND LEVELS OF COVER (CONTINUED)

4.2/ Repatriation assistance cover

Membership: ◯ individual ◯ couple ◯ principal insured + ☐ child/children ◯ family (3 individuals or more)

Area of cover: ◯ European and Mediterranean countries ◯ Worldwide ▸ **Annual premium (all taxes included):** € ☐☐☐ **B**

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

Area of cover: ◯ Worldwide excluding USA/CANADA ◯ Worldwide ▸ **Annual premium (all taxes included):** € ☐☐☐ **C**

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.
on the level of benefit selected, certain medical formalities may be required. Please refer to page 19 of the brochure.

Principal insured
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):** € ☐☐☐☐.☐☐ **D**

Spouse
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):** € ☐☐☐☐.☐☐ **E**

Name of beneficiaries (individuals only)

4 **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):

.....

.....

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 20 of the brochure.

Principal insured

Net annual salary[1,2]: € ☐☐☐☐☐☐

• Amount of daily benefit requested (between €20 and €200): € ☐☐☐

• Deferred period: ◯ 30 days ◯ 60 days

Is the principal insured in a business start-up situation? ◯ YES ◯ NO

▸ **Annual premium (all taxes included):** € ☐☐☐☐.☐☐ **F**

Please attach a copy of your most recent Notice of Assessment and payslip.

CHOICE OF BENEFITS AND LEVELS OF COVER (CONTINUED)

Spouse

Net annual salary[1,2]: € ☐☐☐☐☐☐

• Amount of daily benefit requested (between €20 and €200): € ☐☐☐

• Deferred period: ◯ 30 days ◯ 60 days

4 Is the spouse in a business start-up situation? ◯ YES ◯ NO

▸ **Annual premium (all taxes included):** € ☐☐☐☐ . ☐☐ G

Please attach a copy of the most recent Notice of Assessment and payslip of your spouse.

[1] *Mandatory fields* [2] *If you are starting or taking over a business, the monthly equivalent of the income protection benefit cannot exceed 70% of your previous net monthly income.*

5 **Choice of effective date:** ☐☐ / ☐☐ /2016 **(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

SELECT THE PAYMENT FREQUENCY:	Tick your chosen payment method:			
	SEPA direct debit from a bank account in Euros (accepted countries: France, Monaco and Germany)	Credit or debit card	Bank transfer	Cheque
Annually	☐	☐	☐	☐
Twice yearly	☐	☐ €23 per semester or €46 per year	☐ €23 per semester or €46 per year	☐ €23 per semester or €46 per year
Quarterly	☐	☐ €23 per quarter or €92 per year	☐ €23 per quarter or €92 per year	☐ €23 per quarter or €92 per year
Monthly	☐			

Calculating the annual premium

Total annual premiums (all taxes included): A + B + C + D + E + F + G : € ☐☐☐☐☐ . ☐☐ H

Annual membership fee of the Association des Assurés d'APRIL International in addition to selected benefits: + € ☐2 . 00 I

Annual management fee in addition to selected benefits: + € 28 . 00 J

Annual instalment charges (unless you are paying by SEPA direct debit or annually): + € ☐☐ . ☐☐ K

6 **Total premiums* for 12 months:** H + I + J + K: € ☐☐☐☐☐ . ☐☐ L

*Premiums may be readjusted on 1st January each year depending on the claims history of the insured group.

Total amount of first premium: € ☐☐☐☐☐ . ☐☐

If you want your policy to take effect on the 16th of the month, you should divide the first monthly premium by two. The first premium is a pro rata amount of the annual premium which is valid from the effective date of your policy until 31/12/2016. When calculating your premium, remember to take into account the payment frequency selected.

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 details using the box on page 19.

Paying future premiums:

◯ by cheque, bank transfer or credit/debit card. For these three payment methods, I understand that it is my responsibility to make the payments when they are due.

◯ by SEPA direct debit. Please send us your bank details and fill in the attached SEPA direct debit mandate.

Paperless premium notices are available by e-mail or in your online Customer zone. If you would also like to receive a paper version, please tick the following box: ◯

SIGNATURE OF THE APPLICATION

I hereby apply for membership of the Association des Assurés d'APRIL International under their agreements with Axéria Prévoyance and ACE Europe for the insured 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 ACE Europe and Solucia PJ under this policy.

I have read the General conditions Am 2016 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.

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. APRIL International Expat has the right to utilise certain administrative information and to share it with associated businesses 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.

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.

7 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 confirm that I have answered all of the questions accurately and honestly and have neither included or omitted anything which could mislead the insurers of the present policy.

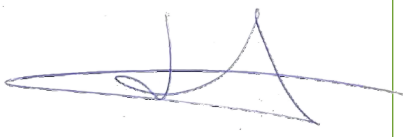
Signed in (town or city) _____ Date d d / m m / y y y y

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 + APRIL International Expat Code:

I 6 6 4 9 9



BML Services (ehealthscanner)

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION

1

This Health questionnaire is valid for 6 months.

For example, if you want your policy to start on 01/07/2016, you can sign the questionnaire between 01/01/2016 and 30/06/2016.
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.

8

SURNAME: ..... FIRST NAME(S): .....

DATE OF BIRTH: |_|_|_|_|_|_|_|_| HEIGHT: |_|_|_| cm WEIGHT: |_|_|_| kg

1	a) Are you **currently on total or partial sick leave from work**?	◯ YES ◯ NO	Reason: ..... Start date: |_|_|_|_|_|_|_|_|
	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: |_|_|_|_|_|_|_|_| End date: |_|_|_|_|_|_|_|_|
	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 **after-effects**?	◯ YES ◯ NO	Date of accident: |_|_|_|_|_|_|_|_| Location of after-effects: ..... Nature of after-effects: .....
4	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: .....
	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: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION (CONTINUED)

1

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? .....
8	**Do you currently suffer or have you suffered over the last 10 years from the following 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: .....
	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: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION (CONTINUED)

8	**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: .....
	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: .....
8	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: .....
	l) **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: __/__/____ 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: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION (CONTINUED)

1

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: __ __ __ __ __ __ __ __ 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: ....

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.

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 insured preceded by the words "I **have read, understood and accepted the policy document**":
Signature of the father, mother or legal guardian for insured children under 18:

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION

2

This Health questionnaire is valid for 6 months.

For example, if you want your policy to start on 01/07/2016, you can sign the questionnaire between 01/01/2016 and 30/06/2016.
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.

8

SURNAME: ..... FIRST NAME(S): .....

DATE OF BIRTH: |_ _|_ _|_ _ _ _| HEIGHT: |_ _ _| cm WEIGHT: |_ _ _| kg

1	a) Are you **currently on total or partial sick leave from work**?	◯ YES ◯ NO	Reason: ..... Start date: |_ _|_ _|_ _ _ _|
	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: |_ _|_ _|_ _ _ _| End date: |_ _|_ _|_ _ _ _|
	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 **after-effects**?	◯ YES ◯ NO	Date of accident: |_ _|_ _|_ _ _ _| Location of after-effects: ..... Nature of after-effects: .....
4	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: .....
	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: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION (CONTINUED) 2

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? .....
8	**Do you currently suffer or have you suffered over the last 10 years from the following 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: .....
	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: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION (CONTINUED) 2

8	**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: .....
	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: .....
8	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: .....
	l) **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: __/__/____ 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: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER, DEATH BENEFIT AND INCOME PROTECTION (CONTINUED) 2

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: __ __ __ __ __ __ __ __ 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: ....

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.

ADDITIONAL INFORMATION .....

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THE INSURERS' MEDICAL EXAMINERS RESERVE THE RIGHT TO REQUEST FURTHER MEDICAL EXAMINATIONS.

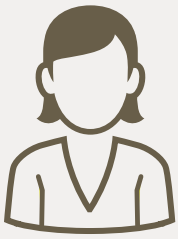
Any non-disclosure, intentional misrepresentation or inaccuracy altering the nature of the risk or influencing the insurers to reduce the risk will result in the cancellation of all cover under the policy. In such circumstances the premium will not be refunded (art. L113-8 of the French Insurance Code).

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.

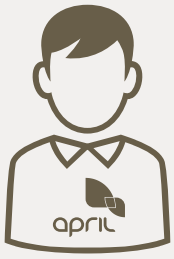
Signed in (town or city) _____ Date d d / m m / y y y y

Signature of the insured preceded by the words "I **have read, understood and accepted the policy document**":
Signature of the father, mother or legal guardian for insured children under 18:

YOUR APPLICATION STEP BY STEP:



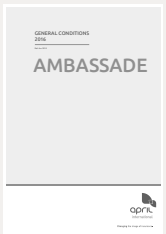
Fill in your Application form and send it to APRIL International Expat.
If you need help, read the tips on the last page or contact us.

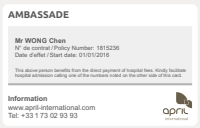


Your application is processed on receipt.

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 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

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. 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.

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

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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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Changing the image of insurance.