APPLICATION FORM

MY TEMPORARY COVER ABROAD

Insurance made easy.

APPLICATION FORM

Insurance consultant reference number: | 5 4 5 9 8

Are you already customer at APRIL International Care France? ◯ YES ◯ NO

If YES, please indicate your Customer Number: C

File reference:

◯ **MySTUDIES COVER**

◯ **MyTRAVEL COVER**

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 (MM/DD/YYYY): / /

Country of nationality:

Country of destination:

Occupation (detailed):

Are you student or equivalent or au pair? YES ◯ NO ◯

Are you already abroad (outside your country of nationality)? YES ◯ NO ◯

If yes, since when (MM/YYYY)? /

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Email:

Title of **spouse**: Mrs ◯ Mr ◯

Surname of **spouse**:

First names of **spouse**:

Date of birth (MM/DD/YYYY): / /

Country of nationality:

Country of destination:

Occupation (detailed):

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Email:

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

Surname of **1st dependent child**:

First name **1st dependent child**:

Date of birth (MM/DD/YYYY): / /

Sex: Male ◯ Female ◯

Social Security number/CFE number:

Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **2nd dependent child**:

First name **2nd dependent child**:

Date of birth (MM/DD/YYYY): / /

Sex: Male ◯ Female ◯

Social Security number/CFE number:

Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **3rd dependent child**:

First name **3rd dependent child**:

Date of birth (MM/DD/YYYY): / /

Sex: Male ◯ Female ◯

Social Security number/CFE number:

Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **4th dependent child**:

First name **4th dependent child**:

Date of birth (MM/DD/YYYY): / /

Sex: Male ◯ Female ◯

Social Security number/CFE number:

Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **5th dependent child**:

First name **5th dependent child**:

Date of birth (MM/DD/YYYY): / /

Sex: Male ◯ Female ◯

Social Security number/CFE number:

Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **6th dependent child**:

First name **6th dependent child**:

Date of birth (MM/DD/YYYY): / /

Sex: Male ◯ Female ◯

Social Security number/CFE number:

Check digit:

(if you are applying for Social Security/CFE top-up insurance)

PRINCIPAL INSURED — Address for delivery of correspondence

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

Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: + Mobile: +

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**

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

Title: Mrs ◯ Mr ◯

Surname:

First names:

Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: + Mobile: +

Email:

DURATION AND LEVEL OF COVER

Period of cover (MM/DD/YYYY): from □□ / □□ / □□□□ to □□ / □□ / □□□□

1 **Type of cover selected:**

◯ **Comfort option with reimbursements:**
- → ◯ from the 1st €
- → ◯ with CFE cover and APRIL as a top-up
- → ◯ as a top-up to French Social Security
- → ◯ as a top-up to EHIC

◯ **Emergency option with reimbursements from the 1st euro**

2 **Type of membership:**
- → ◯ for the principal insured only
- → ◯ for the principal insured and the spouse
- → ◯ for the principal insured, the spouse and/or the children

YOUR TRIP

Reason for trip: Studies ◯ Internship ◯ Language course ◯ Au pair placement ◯ Tourism ◯ Business trip ◯
Working Holiday Visa (WHV) ◯ Self-employed person ◯ Volunteering ◯ Other ◯

School / Employer / Host organisation:

FOR MEDICAL EXPENSES, YOU CAN BE REIMBURSED BY:

◯ 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

Default choice, the insured names as beneficiary (or beneficiaries) in the event of his 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 concerning inheritance; third, equally my ascendants and fourth my other heirs.

The insured can edit the benefiary (or beneficiaries) in the event of his death for the personal accident benefit during the period of cover.

CALCULATING AND PAYING THE PREMIUM

CHOOSE HOW YOU WANT TO PAY YOUR PREMIUM	Choose your preferred payment method by ticking one of the following options:	
	SEPA direct debit from a bank account in Euros	Bank card or PayPal
Single payment	–	◯
Monthly instalments	◯	–

Please note that payments by checks are not accepted

▸ CALCULATING THE PREMIUM

APRIL premium (including the fees for membership of the Association des Assurés APRIL): € ,

If you have chosen a cover as a top-up of CFE : premium for CFE cover + € ,

Instalment charges (unless you are making a single payment): + € ,

Total premium: € ,

For the monthly instalment:

Total amount of 1st premium: € ,
Your 1st payment is the 1st instalment of the total premium.

Pay the 1st premium:

◯ With PayPal (only in case of online subcription).

◯ By bank card (Eurocard-Mastercard and Visa and American Express).

Please enter your card details in the box on page 10.

SIGNING THE APPLICATION

I hereby apply for membership of the Association des Assurés APRIL under their agreements with Groupama Gan Vie for medical expenses (plan numbers 219/636815, 219/636816, 219/636817, 219/636818) and Chubb European Group SE for repatriation assistance cover, personal liability (private capacity and internships), personal accident, bagages insurance, travel incident and stay interruption (plan numbers FRBOTA40912, FRBOTA41180), for the insured members listed on the Application form. I have read the Association's statutes and regulations (available in the General Conditions).

I have read the Insurance Product Information Document (Mtc2019IPID) and the General conditions Mtc2019 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 Care France'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 understand that APRIL International Care France is required to collect my personal data. Information on how the data is processed and how I can exercise my rights in respect of this data can be found in the APRIL International Care France "Information notice - the processing of your personal data (RGPD)" provided to me.

I accept that the information collected in this form is stored in a electronic file by the insurer, the member or their partners and service providers for the management of your selected benefit and within the framework of the information notice. I have the right to access, rectify and object to the processing of my data. I can exercice these rights by mail (APRIL International Care France - Service Courrier - 1 rue du Mont - CS80010 - 81700 Blan) or by email (dpo.AICF@april.com).

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

If I select the Caisse des Français de l'Etranger (CFE) cover and APRIL as top-up, I must notify CFE and APRIL International Care France of any change in my circumstances. I note that APRIL International Care France will collect on behalf of CFE the premiums and the reimbursements of my medical expenses in order to make a unique payment on my bank account. I agree that CFE and APRIL International Care France exchange any administrative and medical information which is necessary to the management of my plan.

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 Care France 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 agree to pay back to APRIL International Care France any amount reimbursed to me by Social security and/or any private healthcare insurer.

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 (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

(We cannot accept applications signed in the United States.)

Signature(s) of the person to be 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 Care France Code:** I☐☐☐☐☐☐☐

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

CANCELLATION

ARTICLE L.112-9 OF THE FRENCH INSURANCE CODE

To waive your policy, please use the tear-off slip below and send it to:
APRIL International Care France - Service Courrier - 1 rue du Mont - CS 80010 - 81700 Blan - FRANCE

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: **MyStudies Cover / MyTravel Cover Ref: Mtc2019**

Date of signature of Application form (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Member's surname:

Member's first name:

Member's address:

Post code: City:

Country:

Telephone:

Name of insurance consultant:

Address of insurance consultant:

Post code: City:

Country:

Telephone:

Date (MM/DD/YYYY):
☐☐ / ☐☐ / ☐☐☐☐

Member's signature:

Reserved for APRIL International Care France: Client reference number C☐☐☐☐☐☐☐☐☐

MY TEMPORARY COVER ABROAD — HEALTH QUESTIONNAIRE 1/3

Surname: First Name(s):

Date of birth (MM/DD/AAAA): / /

◯ MySTUDIES COVER ◯ MyTRAVEL COVER

VERY IMPORTANT

This Health questionnaire is valid for 3 months

For example, if you want your insurance to start on 01/04, you can sign the questionnaire between 01/01 and 31/03.

1 ARTICLE L.113-8 OF THE FRENCH INSURANCE CODE: Irrespective of the ordinary causes of nullity and subject to the provisions of article L132- 26, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the insured member, when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the insured concealed or distorted has no impact on the claim.

2 PLEASE READ THE FOLLOWING QUESTIONNAIRE VERY CAREFULLY: your attention is drawn to the importance of this questionnaire. All of the questions must be answered and the questionnaire must be signed and dated. 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.

3 CONFIDENTIALITY: regardless of the responses given in this Health questionnaire, it is important to send it with your Application form **in a sealed envelope marked "CONFIDENTIAL"** to the Medical Examiner, **together with any medical documents which will assist with the processing of your application**, at the address below:

APRIL International Care France
Service Courrier (mail service) - À l'attention du Médecin Conseil - 1 rue du Mont - CS 80010 - 81700 Blan - FRANCE

YOUR HEIGHT/WEIGHT: Centimeters Kilogrammes **OR:** Inches Pounds

DURING THE LAST FIFTEEN YEARS

1	**ONLY FOR PEOPLE WHO HAVE THE FRENCH SOCIAL SECURITY OR CFE** Before enrolling in this plan, were you or are you entitled to 100% French Social Security coverage on medical grounds? If so, please mention the pathology. If you are not concerned, please select "**NO**"	☐ NO ☐ YES	*Reason(s):* *Date(s):* *Duration(s):*

DURING THE LAST TEN YEARS

2	**Have you been hospitalised and/or undergone surgery** including by endoscopy (other than caesarean section, benign appendectomy, wisdom teeth, removal of tonsils or adenoids in childhood) or any other?	☐ NO ☐ YES	*Reason for hospitalisation:* *Date(s):* *Type of surgery:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If **YES**, please provide details:*

MY TEMPORARY COVER ABROAD HEALTH QUESTIONNAIRE 2/3

Surname: First Name(s):

Date of birth (MM/DD/AAAA): ☐☐ / ☐☐ / ☐☐☐☐

DURING THE LAST FIVE YEARS			
3	**Have you had any specialist consultations** for chronic or metabolic cardiac and/or vascular, neurological, respiratory, oncological, psychiatric, psychological, osteo-articular, liver or digestive, disorders?	☐ NO ☐ YES	*Diagnosis/Diagnoses:* *Date(s) and duration(s):* *Date of recovery (MMDDYYYY):* ☐☐ / ☐☐ / ☐☐☐☐ ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If **YES**, please provide details:*
4	**Have you been prescribed any medical treatment** lasting more **than 30 consecutive days**?	☐ NO ☐ YES	*Reason(s):* *Type of conditions and treatment:* *Date(s):* *Duration(s):*
CURRENTLY			
5	**Are you currently suffering from any illnesses and/or conditions,** or are you under **medical care**, or having any **prescribed medical treatment**?	☐ NO ☐ YES	*Type of illness(es) or conditions(s):* *Date(s) of onset:* *Type of medical care:* *Type of treatment(s):*
6	**Have you been tested** for seropositivity to any of the human immunodeficiency viruses (HIV), hepatitis B (HBV) or Hepatitis C (HCV) where any of the **results were « POSITIVE »**?	☐ NO ☐ YES	*If **YES**, please provide details* *Date(s):*
7	**Do you have** any malformations or disabilities or are you suffering from the after-effects of an illness or accident?	☐ NO ☐ YES	*From what date?* *Reason(s):*

MY TEMPORARY COVER ABROAD HEALTH QUESTIONNAIRE 3/3

Surname: First Name(s):

Date of birth (MM/DD/AAAA): / /

OVER THE NEXT TWELVE MONTHS			
8	IS IT PLANNED FOR YOU TO HAVE ANY OF THE FOLLOWING:		
	a) Medical examinations (lab tests, medical imaging, endoscopy) or any other medical examinations, other than routine screening?	☐ NO ☐ YES	*Type of examination:*
			Reason(s):
			Date(s):
	b) A specialist consultation?	☐ NO ☐ YES	*Type of consultation(s):*
			Reason(s):
			Date(s):
	c) Surgery or hospitalisation including on an outpatient basis?	☐ NO ☐ YES	*Type of surgery or hospitalisation:*
			Reason(s):
			Date(s):

Further details where the response to the question was YES:
To help us process your application, please provide us with as much detail as possible about the illnesses or conditions reported in the Health questionnaire. We would also recommend you enclose copies of **any MEDICAL REPORTS or ADDITIONAL DOCUMENTS** that may help our medical department process your application as quickly as possible: **hospital report, post-operative report, results and reports in respect of any additional examinations carried out (biological tests, imaging, specialist examinations, etc.), latest consultation reports, latest prescriptions, recent medical certificate, etc.**

ADDITIONAL INFORMATION

I certify the accuracy and honesty of these statements. The data collected by the insurer is required for the execution, management and implementation of the membership and its legal basis is the implementation of contractual measures. This data may also be used for the purpose of fraud prevention and may in some cases lead to inclusion on a list of persons presenting a risk of fraud. In this case, its legal basis is the legitimate interest of the insurer. This information is processed in compliance with the rules of medical confidentiality. It is intended for the insurers' medical examiners and their medical department or internal or external persons with specific authorisation.
I understand that APRIL International Care France is required to collect my personal data. Information on how the data is processed and how I can exercise my rights in respect of this data can be found in the APRIL International Care France “Information notice - the processing of your personal data (RGPD)” provided to me.

Signed in (town or city) ..... on (current date MM/DD/YYYY): / /

Signature of the person to be insured preceded by the words **"Read and approved"**:
Signature of the legal representative for insured children:

WE ARE DELIGHTED YOU WANT TO BECOME A MEMBER.

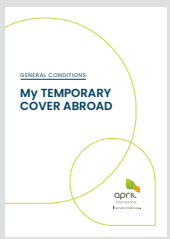
THESE ARE THE STEPS TO FOLLOW TO APPLY FOR MEMBERSHIP OF THE PLAN:

Complete your Application form and send it to APRIL International Care France.
If you need help, please feel free to contact us.

We process your application as soon as it arrives.

You will be sent:

- **your insurance certificate,**
- **your General conditions describing how your plan operates,**
- **your insurance card showing the emergency numbers to use if you need assistance or before going into hospital,**
- **your Members' guide with a summary of how your plan operates and all the contact details you will need.**



SEPA DIRECT DEBIT MANDATE

(to be completed if selecting payment by direct debit)

april international
Insurance made easy.

Unique Mandate Reference (to be completed by the creditor):

By signing this mandate form, you authorise (A) APRIL International Care France 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 Care France.

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:

Name of bank:

Type of payment* (tick where appropriate): ☑ Recurring payment ○ One-off payment

CREDITOR:

APRIL International Care France - 14 rue Gerty Archimède - 75012 PARIS - FRANCE

SEPA creditor identification number: FR54ZZZ004082

Signed in (town or city)*:

Date (DDMMYYYY)*: / /

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 Care France in order to manage your direct debit payments and will be sent only to your bank for this purpose. In accordance with (EU) Data Protection Regulation No. 2016/679 of 27th April 2016, you have the right to access your personal information, have it corrected, deleted, opt out of this information being processed and restrict its processing and portability. You also have the right to set guidelines with respect to the storage, deletion and transfer of this data after your death. You can exercise these rights by contacting our Data Protection Officer at dpo.AICF@april.com.

Please return this form to APRIL International Care France 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 ◯ American Express

Card number: ☐☐☐☐/☐☐☐☐/☐☐☐☐/☐☐☐☐ Expiry date: ☐☐/☐☐

Card security code: ☐☐☐☐ (the 3 digit number printed on the backside of your Mastercard and VISA branded card or a 4 digit number on the front side of your American Express card).

Card owner: