APPLICATION FORM
2018

V.I. XCLUSIVE

LONG-TERM SOLUTION
(COVER FOR MORE THAN 12 MONTHS)

april international

Insurance made easy.

V.I. XCLUSIVE APPLICATION FORM

Are you a returning customer at April International? ◯ YES ◯ NO If so, please indicate your Customer Number: C

Period of international assignment: from d d / m m / y y y y to d d / m m / y y y y

IMPORTANT: PLEASE INCLUDE A COPY OF YOUR VOLUNTEER MISSION ORDER WITH THIS APPLICATION

PLEASE WRITE IN CAPITAL LETTERS

INSURED Person(s) to be insured

If you have more than 2 dependent children, please make a copy of page 2 and fill it out.

Title of **main insured**: Mrs ◯ Mr ◯

Last name of **main insured**:

First names of **main insured**:

Date of birth: d d / m m / y y y y *(max. 36 years old)*

Country of nationality:

Country of destination:

Occupation (detailed):

Business sector:

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

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

Email:

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Title of **spouse**: Mrs ◯ Mr ◯

Last name of **spouse**:

First names of **spouse**:

Date of birth: d d / m m / y y y y *(max. 36 years old)*

Country of nationality:

Country of destination:

Occupation (detailed):

Business sector:

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

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

Last name of **1st dependent child**:

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

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

Last name of **2nd dependent child**:

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

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

MAIN INSURED — Address for delivery of correspondence

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Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: +

Mobile: +

Any correspondence from us (your insurance certificate, General conditions, reimbursement statements etc.) will be sent by e-mail.

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

MEMBER = WHO IS PAYING THE PREMIUM

◯ **The main insured is paying the premium** (in this case, it is not required to fill out the below information)

◯ **The person paying the premium is not the main insured**

Individual ◯

Corporate ◯ Name of company:

Title: Mrs ◯ Mr ◯

Last name:

First names:

Address :

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Postcode:

City:

State/Region/Land/County:

Country :

Landline : +

Mobile: +

Email:

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

CHOICE OF BENEFITS

◯ Medical expenses

OR

◯ Medical expenses + repatriation assistance + personal liability (private capacity) + personal accident

Area of cover: ◯ Zone 1 ◯ Zone 2

4 To calculate your premium, please refer to the VI Xclusive leaflet on page 12

▸ Annual premium (all taxes included) for medical expenses: € A

▸ Annual premium (all taxes included) for repatriation assistance and personal liability (private capacity): € B

▸ Annual premium (all taxes included) for personal accident: € C

▸ **Total premiums (all taxes included):** €

FOR MEDICAL EXPENSES, YOU CAN BE REIMBURSED BY:

5

◯ 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 and your bank's address.

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

DESIGNATION OF BENEFICIARIES IN THE EVENT OF DEATH - PERSONAL ACCIDENT BENEFIT

Main 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 the last name(s), name(s), date and place of birth and percentage of the capital to be allocated):

.....

.....

.....

6

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 the last name(s), name(s), date and place of birth and percentage of the capital to be allocated):

.....

.....

.....

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

7 **Choice of effective date:** ☐☐ / ☐☐ /2018 **(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 (domiciled in the SEPA area)	Credit or debit card	Bank transfer	Cheque
Annually	◯	◯	◯	◯
Twice yearly	◯	◯ €20 per semester or €40 per year	◯ €20 per semester or €40 per year	◯ €20 per semester or €40 per year
Quarterly	◯	◯ €20 per semester or €80 per year	◯ €20 per semester or €80 per year	◯ €20 per semester or €80 per year
Monthly	◯			

Calculating the annual premium

Total annual premiums (all taxes included): **A** + **B** + **C**: € . **D**

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

Annual management fee in addition to selected benefits: + € 18 . 00 **F**

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

8 **Total premiums* for 12 months: D + E + F + G:** € . **H**

*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 be effective on the 16th of the month, your premium will be calculated on the basis of one full month (until the 16th of the following month).
If you wish to pay twice yearly, quarterly or monthly, you need to divide your premiums by 2, 4 or 12.

Paying the first premium:

◯ by cheque **payable to APRIL International Care** or bank transfer.
◯ by credit or debit card (Eurocard-Mastercard and Visa only).

Please provide your card details using the box on page 17.

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.

SIGNING THE APPLICATION

I hereby apply for membership of the Association des Assurés d'APRIL International under their agreements with Allianz Worldwide Care SA for medical expenses (plan number 080538/501) and TOKIO MARINE KILN INSURANCE LIMITED for repatriation assistance cover, personal liability (private capacity) and personal accident cover (plan number FR008367TT), for the insured members listed on the Application form. I have read
9 the Association's statutes and regulations (available for download at http://assoexpat-a3i.fr/association).

I have read the General conditions VI Expat 2018 outlining the details of my insurance cover. I am aware of my right to cancel the insurance and accept the terms and conditions. I have retained a copy of these. I also understand the terms and conditions of APRIL International Expat's handling of my insurance cover. If my insurance cover is subsequently amended, I accept that the General conditions applied will be those outlined above.

SIGNING THE APPLICATION (CONTINUED)

French legislation governing data protection and freedom of information:

In accordance with the French Data Protection and Freedom of Information Act of 6th January 1978, amended, I have been informed by APRIL International Care, in their capacity as processor of the information that:

- the information collected is required in order to assess my claims for reimbursement, the administration of my plan and the processing of my application. This administrative information is processed electronically by APRIL International Care, the insurers or their agents for the requirements of provision of my insurance cover. The company, APRIL International Care may contact me by telephone regarding my application for insurance unless I opt out by sending an email to: adhesion.expat@april-international.com or by writing to the address shown below;
- I have the right to opt out of telephone marketing and may exercise this right by sending a letter to OPPOSETEL- Service Bloctel - 6, rue Nicolas Siret - 10000 TROYES or on the website www.bloctel.gouv.fr;
- I have the right to access, transfer and, if necessary, rectify any information about me which is held in these files by writing to APRIL International Care France, Service Courrier (mail service), 1 rue du Mont, CS 80010, 81700 Blan, FRANCE. APRIL International Care may use certain administrative information and pass it on to the subsidiaries of the APRIL group to enable them to offer me new products or services. I may opt out of these offers by sending a standard letter to APRIL International Care (at the above-mentioned address). My postal charges will be refunded;
- 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.
- My personal information may also be used for the purposes of combatting insurance fraud, in its capacity as a financial organisation, APRIL International Care has introduced 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 may 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 and Freedom of Information 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 the above-mentioned address.

Retention of data - My data will be retained for the prescribed periods of time.

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

9

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

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 Care 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 Care and my treating doctors to exchange any information, including medical details, required for the management of my claims.

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

◯ I would like to receive offers from APRIL's partners by email.

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

Signature(s) of the main insured and insured spouse preceded by the words "**I have read, understood and accepted the policy document**":

Signature of the member (if different from the insured) preceded by the words "**I have read, understood and accepted the policy document**":

ACCORDING TO YOUR PROFILE, YOU MAY BE REQUIRED TO FILL OUT OUR HEALTH DECLARATION OR HEALTH QUESTIONNAIRE:

PROFILE 1:
YOU WERE INSURED BY APRIL DURING YOUR INTERNATIONAL ASSIGNMENT WHICH ENDED **LESS** THAN 3 MONTHS AGO

WE ASK THAT YOU SIMPLY FILL OUT THE
HEALTH DECLARATION
> Go to page 8

PROFILE 2:
YOU WERE INSURED BY APRIL DURING YOUR INTERNATIONAL ASSIGNMENT WHICH ENDED **MORE** THAN 3 MONTHS AGO

WE ASK THAT YOU FILL OUT THE
HEALTH QUESTIONNAIRE
> Go to pages 9 to 12

PROFILE 3:
YOU WERE INSURED BY AN INSURANCE OTHER THAN APRIL DURING YOUR INTERNATIONAL ASSIGNMENT

WE ASK THAT YOU FILL OUT THE
HEALTH QUESTIONNAIRE
> Go to pages 9 to 12

PLEASE NOTE: the waiting periods may be waived (except for maternity cover) if you can prove that you have had medical expenses cover equivalent to or greater than the V.I. Xclusive benefits in the month preceding the effective date of this policy.

HEALTH DECLARATION
TO BE COMPLETED ONLY IF YOU WERE INSURED BY APRIL DURING YOUR INTERNATIONAL ASSIGNMENT WHICH ENDED LESS THAN 3 MONTHS AGO

This health declaration is valid for 6 months.

For example, if you want the policy to start on 01/07/2018, the declaration must be dated between 01/01/2018 and 30/06/2018.

If the policy covers more than 2 people, please make a copy of the declaration.

If you are unable to complete this form, please contact us

Last name and first name of person(s) to be insured:

Main insured :

Spouse:

Child(ren):

"I declare that I am in good health and do not suffer from any incapacity, disability or illness for which I am currently receiving treatment and which is likely to reoccur or develop.

10 I declare that I have not undergone any medical treatment lasting more than one month during the last three years and do not plan to undergo any medical treatment or surgery in the country I will be visiting during the period of cover.

I declare that I do not plan to be hospitalised within 12 months of the start date of my policy for any reason whatsoever (removal of tonsils or cysts, knee surgery, childbirth etc.).

I authorise the Medical Examiner to request any information they consider necessary from the doctors who have treated me or whom I have consulted. I authorise these doctors to pass on the requested information under confidential cover to the Medical Examiner.

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 the policy. In such circumstances the premium will not be refunded (art. L113-8 of the French Insurance Code).

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 this policy."

Signed in (town or city)

Date d d / m m / y y y y

Signature(s) of the main insured preceded by the words "**I have read, understood and accepted the policy document**":

Signature of the spouse preceded by the words "**I have read, understood and accepted the policy document**":

HEALTH QUESTIONNAIRE

This Health questionnaire is valid for 6 months.

For example, if you want your policy to start on 01/07/2018, the questionnaire must be dated between 01/01/2018 and 30/06/2018.
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 make a copy of the questionnaire.

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.

The Health questionnaire below is to be filled out and sent 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 Care France, Service Courrier (mail service), 1 rue du Mont, CS 80010, 81700 Blan, 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.

LAST NAME: ..... FIRST NAME(S): .....

10 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 (CONTINUED)

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: .....

10

HEALTH QUESTIONNAIRE (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: .....
10	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 (CONTINUED)

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.

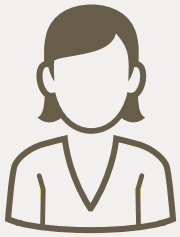
Any non-disclosure, intentional misrepresentation or inaccuracy altering the nature of the risk or influencing the insurers to reduce the risk will result in the cancellation of all cover under the policy. In such circumstances the premium will not be refunded (art. L113-8 of the French Insurance Code).

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:

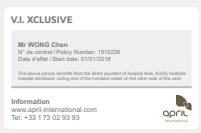


Fill in your Application form and send it to APRIL International Care.
If you need help, read the tips on the next page or contact us.

Your application is processed upon receipt.

You will then receive:

- **your Membership certificate serving as your insurance certificate,**
- **the General conditions showing how your policy operates,**
- **your insurance card containing emergency contact numbers for requesting assistance services or before admission to hospital.**



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 Care 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.

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 last name*:

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 Care - 14, rue Gerty Archimède - 75012 Paris - 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 Care 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 Care.

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

Creditor's use only

To waive your policy, please use the tear-off slip below and send it to:
APRIL International Care France, Service Courrier (mail service), 1 rue du Mont, CS 80010, 81700 Blan, 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 waive 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: **V.I. Xclusive VI Expat 2018**

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

Member's last name:

Member's first name:

Member's address:

Postcode: City:

Country:

Telephone: / / / / /

Date and member's signature:

d d / m m / y y y y

Reserved for APRIL International Care: Client reference number C

Please send your completed application to:

APRIL International Care France
Service Courrier (mail service)
1 rue du Mont - CS 80010
81700 Blan - FRANCE

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 your method of reimbursement for medical expenses 5.

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

E. Indicate the date on which you want your cover to take effect 7.

F. Calculate your premium and indicate your selected method of payment 8.

G. Date and sign your application in part 9.

H. Date, complete and sign the health declaration or health questionnaire, depending on your status 10.

I. For the payment of your first premium, you can:
- enclose a cheque payable to APRIL International Care, *OR*
- provide your credit/debit card details at page 17 of the Application form, *OR*
- arrange for a bank transfer (in this case, attach a copy of the transfer order).

J. 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 Euro.

K. If you wish to request a waiver for the waiting periods that apply to the medical expenses cover, please enclose your certificate of insurance from your previous policy with details of your cover.

Send your Application form and supporting documents to
APRIL International Care France, Service Courrier (mail service),
1 rue du Mont, CS 80010, 81700 Blan, FRANCE

WHAT HAPPENS NEXT?

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

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

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

april International Care

Headquarters:

APRIL International Care France - 14, rue Gerty Archimède - 75012 Paris - FRANCE
Tel: +33 (0)173 02 93 93 - Fax: +33 (0)173 02 93 90 -
Email: info.expat@april-international.com - **www.april-international.com**

A French simplified joint-stock company (S.A.S.) with capital of €200,000 - 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° FR60309707727

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Insurance made easy.