APPLICATION FORM
2018

V.I. XCLUSIVE

SHORT-TERM SOLUTION
(COVER FOR UP TO 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. 31 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. 31 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 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 ◯

DURATION AND LEVEL OF COVER

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

FOR MEDICAL EXPENSES, YOU CAN BE REIMBURSED BY:

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- ◯ 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):

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Spouse: I name as beneficiary (or beneficiaries) in the event of my death:

- ◯ My surviving spouse on condition that we were not legally separated when the lump sum became payable, second, equally, my children living, to be born or represented as such; third, equally my ascendants and fourth my other heirs.
- ◯ Other beneficiaries (please specify the last name(s), name(s), date and place of birth and percentage of the capital to be allocated):

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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.

CALCULATING THE PREMIUM

Minimum period of cover: 1 month; maximum 12 months.

Calculating the premium

Taking into account the number of adults and children to be covered and the payment method (full payment or monthly instalments), please refer to page 12 of the brochure to calculate the amount of the premium.

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

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- ▸ Premium for main insured: €☐☐☐☐
- ▸ Premium for spouse: + €☐☐☐☐
- ▸ Premium for child(ren): (€☐☐☐☐ X ☐ child(ren)): + €☐☐☐☐
- ▸ Instalment charges for monthly payment (€3 X ☐☐ months): + €☐☐☐☐
- ▸ **Total premium (all taxes included):** = €☐☐☐☐

SELECTING THE PAYMENT METHOD

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

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

Please provide your card details using the box on page 11.

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◯ **Payment in monthly instalments** (by SEPA direct debit from a bank account domiciled in the SEPA area)

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

You wish to pay the first premium by:

- ◯ **credit/debit card** (please provide your card details using the box on page 11)
- ◯ **cheque** (please make it payable to **APRIL International Care**)

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 080538/502) and TOKIO MARINE KILN INSURANCE LIMITED for repatriation assistance, personal liability (private capacity) and personal accident cover (plan number FR008367TT), for the insured members listed on the Application form. I have read the Association's statutes and regulations (available for download at http://assoexpat-a3i.fr/association).

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I have read the General conditions VI Pack 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.

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

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.

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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 principal insured) preceded by the words "**I have read, understood and accepted the policy document**":

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 France, Service Courrier (mail service), 1 rue du Mont, CS 80010, 81700 Blan, FRANCE enclosing a copy of your bank account details.

Creditor's use only

Please send your completed application to:

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

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 Pack 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:

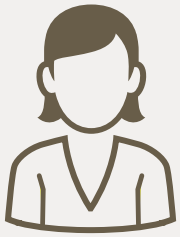
Telephone: / / / / /

Date and member's signature:

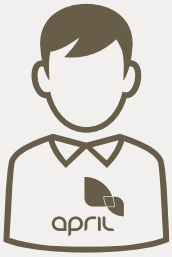
d d / m m / y y y y

Reserved for APRIL International Care: Client reference number C

YOUR APPLICATION STEP BY STEP:



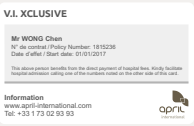
Fill in your Application form and send it to APRIL International Care.
If you need help, read the tips on the next page or contact us.



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.**



DATA RELATING TO PAYMENTS BY BANK CARD

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

Type of card: ○ Eurocard-Mastercard ○ Visa

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

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

Card owner:

TAKING OUT THE INSURANCE

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

B. Choose the duration of your cover 4.

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

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

E. Taking into account the number of adults and children to be covered, please refer to page 8 of the brochure to calculate the amount of the premium and fill it in 7.

F. Indicate your selected method of payment 8.

G. Date and sign your application 9.

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

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

Send your Application form and supporting documents to
APRIL International 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 day following receipt of your application form and supporting documents.

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**

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Prudential Supervision and Resolution Authority - 61, rue Taitbout - 75436 Paris Cedex 09 - FRANCE
NAF6622Z - Intra-community VAT N° FR60309707727

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