APPLICATION FORM
2019

CRYSTAL STUDIES

april international

Insurance made easy.

APPLICATION FORM CRYSTAL STUDIES

Insurance consultant reference number: I

Are you already customer at APRIL International Care France? ◯ YES ◯ NO If yes, please indicate your Customer Number: C

PLEASE WRITE IN CAPITAL LETTERS

INSURED Person to be insured

Title: Mrs ◯ Mr ◯ Date of birth: d d / m m / y y y y (upper age limit of 40)

Surname:

First names:

Country of nationality:

Country of destination:

Contact information / Address for delivery of correspondence

Email :

1 If you are travelling to the United States, please send us your full address so that we can send you your third party payment card for pharmacy expenses.

Address:

Postcode: City:

State/Region/Land/County:

Country:

Telephone: + / Cell phone: + /

Any correspondence from us (your insurance certificate, general conditions, reimbursement statements etc.) will be sent by email. Your insurance card will be sent by post.

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

MEMBER = PERSON PAYING THE PREMIUM

◯ **The insured is paying the premium** (in this case, the information below is not required)

◯ **Someone else is paying the premium**

Title: Mrs ◯ Mr ◯

Surname:

First names:

2 Address:

Postcode: City:

State/Region/Land/Country:

Country:

Telephone: + / Cell phone: + /

Email:

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

PERIOD AND LEVEL OF COVER

3 Period of cover required:

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

for a duration of: . months (minimum 1 month, maximum 12 months)

Type of cover selected:

◯ Complete cover ***or*** ◯ Mini cover

◯ 1st euro ***or*** ◯ EHIC top-up

YOUR TRIP

Reason for trip : Study ◯ Leisure ◯ Training ◯ Language course ◯ Au pair placement ◯

School or organisation which the insured attends : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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

ADDITIONNAL INFORMATION FOR THE PERSONAL ACCIDENT BENEFIT (COMPLETE OPTION)

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In the event of death I name as beneficiary:

◯ My surviving spouse on condition that we were not legally separated when the lump sum became payable; second, equally, my children living, unborn or represented as such; third, equally my ascendants and fourth my other heirs

◯ Other beneficiaries (please specify their surname(s), name(s), date and place of birth and percentage of the capital to be allocated):

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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.

CALCULATION OF PREMIUM

Depending on your age band, the choice of option (Mini or Complete), the choice of cover (1st euro or EHIC top-up) and the payment method selected (full payment on application or monthly instalments), go to page 9 of the brochure to calculate your premium.

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Number of months: ☐☐ . ☐ Monthly premium (all taxes included): € ☐☐ **A**

Premium for 15 days (all taxes included): € ☐☐ **B** *(if your trip includes a half-month)*

Total premium (all taxes included): **A** x ☐ month + **B** = € ☐☐☐

Reminder:

- A €3 monthly fee will apply if you choose to pay in monthly instalments. This fee will be added to your premium.
- Payment can be made in monthly instalments if your stay does not include any half-months.

SELECTION OF PAYMENT METHOD

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

- ◯ **cheque,** please make it **payable to APRIL International Care France**
- ◯ **credit/debit card** (Eurocard-Mastercard and Visa only)

Please provide your card details using the box on page 9.

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◯ **Payment in monthly instalments** (SEPA direct debit taken from a euro account domiciled in the single euro payments area: SEPA).

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 9)
- ◯ **cheque** (please make it payable to **APRIL International Care France**)

SIGNING THE APPLICATION

I hereby apply for membership of the Association des Assurés APRIL under their agreements with Groupama Gan Vie for the medical expenses and personal accident benefit (policy n° 219/684930 and 219/684931) and CHUBB for the repatriation assistance and delayed departure (policy n°FFRBBBA07289). I have read the Association's statutes and regulations (available in the General Conditions).

By choosing personal liability (private capacity), baggage and legal assistance cover (included under the Complete Option), I am applying for insurance with CHUBB for the personal liability (private capacity), internships and tenant's liability benefit (contract n°FRBOPA10165) and Solucia PJ for the legal assistance benefit (contract n°1000 66 02).

I certify to be a student or student equivalent or at school for the duration of my Crystal Studies policy and certify to be able to present a photocopy of my student card or a certificate of registration (or a copy of the contract with the host family for au pair placements) valid at any time, on request from APRIL International Care France.

I have read the Insurance Product Information Document (Cs2018IPID) and the General conditions Cs 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 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 understand that cover under the present policy does not exempt me from paying contributions to any state scheme to which I may belong.

I agree to pay back to APRIL International Care France any amount reimbursed to me by Social security and/or any private healthcare insurer (unless an EHIC top-up cover has been selected).

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

8 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 want to receive e-mail information on offers from APRIL partners.

Signed in (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 member (if different from the insured) preceded by the words « **I have read, understood and accepted the policy document** »:
Signature of legal guardian for the minor insurants:

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

HEALTH QUESTIONNAIRE — TO BE COMPLETED FOR MEMBERSHIP OVER THE AGE OF 30

This Health questionnaire is valid for 6 months.
For example, if you want your policy to start on 01/07/2019, you can sign this questionnaire between 01/01/2019 and 30/06/2019.

You must personally answer all the questions as accurately as possible as your responses are binding. This simplified health questionnaire is essential to the evaluation of the risk that the insurer proposes to undertake.
Any unanswered questions will result in further enquiries.

Any medical information you provide is held in strict confidence. Detailed answers will help us process your application promptly.

The Medical Examiner reserves the right to ask the doctors having treated you to confirm the validity and comprehensiveness of the information provided in the Health questionnaire and to ensure that the conditions being treated do not contradict or are not inconsistent with the information provided when the insurance was purchased. This request may be made at any time, including prior to the processing of a claim or the issuing of a hospital cover note.

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 1 rue du Mont - CS80010 - 81700 Blan - FRANCE.

Some of the medical information you provide may be processed electronically for the use of the APRIL International Care France's Medical Examiner. Under the regulation n° 2016/679 from April 27th 2016 about the data protection, you have the right to access and, if necessary, rectify any personal information held on file by writing to the APRIL International Care France's Medical Examiner at the above address.

1	Do you have a condition, an illness or any aftereffect resulting from an accident whether or not it requires regular medical supervision and/or treatment?	◯ YES ◯ NO
2	It is planned over the 12 months following the effective date of cover under your policy for you to be admitted to hospital (for removal of tonsils, knee surgery, removal of a cyst, childbirth or any other reason)?	◯ YES ◯ NO

9 **Further details if the response to one of the question is YES:**
To help us process your application, please provide further details regarding the events surrounding the illness or accident and any consequences resulting from it.

ADDITIONAL INFORMATION .....

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

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

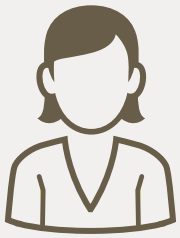
I hereby certify that I have answered all the questions accurately and honestly and have neither included or omitted anything which might mislead the insurers of the present policy.

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

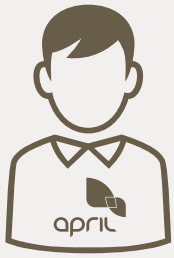
Signature of the insured preceded by the words « I have read, understood and accepted the policy document »:

If the person to be insured is a minor, a parent or legal guardian must sign on his or her behalf:

YOUR APPLICATION STEP BY STEP:



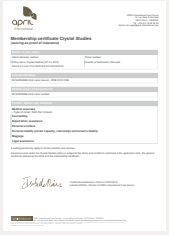
Fill in your Application form and send it to APRIL International Care France.
If you need help, read the tips on the last page or contact us.

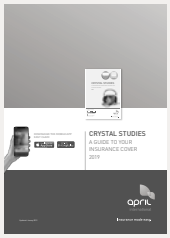


Your application is processed on receipt.

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 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:

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*: 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 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

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 - CS80010 - 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 in case of distance selling by telephone or online, even if this visit was 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 to the above address. It must be sent no later than 14 days on 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: **Crystal Studies Ref. Cs 2018**

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

Member's surname:

Member's first name:

Member's address:

Postcode: City:

Country:

Telephone: / / / / /

Name of insurance consultant:

Address of insurance consultant:

Postcode: City:

Country:

Telephone: / / / / /

Date and member's signature:

d d / m m / y y y y

Reserved for APRIL International Care France: client reference number C

DATA RELATING TO PAYMENTS BY BANK CARD

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

Type of card: ◯ Eurocard-Mastercard ◯ Visa

Card number: ____ / ____ / ____ / ____ Expiry date: __ / __

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

Card owner:

TAKING OUT THE INSURANCE

A. Fill in your personal details (surname, first name, address…) 1 and 2.

B. Select the period and level of cover 3.

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

D. If you are applying for the Crystal Studies "Complete" option, please designate the beneficiary/beneficiaries in the event of death 5.

E. Depending on your age band and your choice of cover (1st euro or EHIC top-up) and the selected method for paying the premium (full payment on application or monthly instalments), refer to page 9 of the brochure to calculate the amount of your premium and fill it in 6.

F. Select the payment type (full or monthly) and the payment method 7.

G Date and sign the Application form 8.

H. Complete, date and sign your Health questionnaire (for membership over the age of 30) 9.

I. Enclose with your application **a cheque in € made payable to APRIL International Care France or provide details of your credit/debit card** on page 9**,** in order to pay your premium in full or to pay your first premium in case of payment in monthly instalments.

J. If you are paying in monthly instalments:
- fill in the attached SEPA direct debit authorisation form on page 7,
- attach your bank details.

Send your application form and supporting documents to
APRIL International Care France - Service Courrier
1 rue du Mont - CS80010 - 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:
14 rue Gerty Archimède - 75012 Paris - FRANCE
Tel.: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90
Email: info.expat@april-international.com - www.april-international.com

A French simplified joint-stock company (S.A.S.) with capital of €200,000 - RCS Paris 309 707 727
Insurance intermediary - Registered with ORIAS under number 07 008 000 (www.orias.fr)
Prudential Supervision and Resolution Authority - 4 place de Budapest - CS 92459 - 75436 Paris Cedex 09 - FRANCE.
This product is conceived and managed by APRIL International Care France and insured by Groupama Gan Vie (for the medical expenses cover), Chubb European Group SE (for the repatriation assistance cover, personal liability private capacity, internships and tenant's liability, personal accident and tuition insurance covers) and by Solucia PJ (for the legal assistance cover).
NAF6622Z - VAT registration number : FR60309707727

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Insurance made easy.