Expat Student

Application Form 2021-2022

Updated: July 2021

APPLICATION FORM EXPAT STUDENT

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(s) to be insured

Title of **principal insured**: Mrs ◯ Mr ◯

Surname of **principal insured**:

First names of **principal insured**:

Date of birth (DDMMYYYY): / / *(12 years old min., 40 years old max.)*

Country of birth:

Country of nationality:

Country of primary residence abroad:

Status of principal insured: Pupil ◯ Student ◯ Au-pair ◯

Degree course/programme: Estimated length of study: years

School or institution of attendance of the principal insured:

Email:

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

Social security number/CFE number: Check digit:

Date of entitlement for the CFE (DDMMYYYY): / /

If you are applying for French Social Security/CFE top-up insurance

1

Are you insured with a social security system in your country of primary residence abroad*?: YES ◯ NO ◯

If YES, which one:

Title of **spouse**: Mrs ◯ Mr ◯

Surname of **spouse**:

First names of **spouse**:

Date of birth (DDMMYYYY): / / *(18 years old min., 40 years old max.)*

Country of birth:

Country of nationality:

Country of primary residence abroad:

Status of principal insured: Pupil ◯ Student ◯ Au-pair ◯

Degree course/programme: Estimated length of study: years

School or institution of attendance of the principal insured:

Email:

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

Social security number/CFE number: Check digit:

Date of entitlement for the CFE (DDMMYYYY): / /

If you are applying for French Social Security/CFE top-up insurance

Are you insured with a social security system in your country of primary residence abroad*?: YES ◯ NO ◯

If YES, which one:

**Person who holds or has within the last year held a prominent political, judicial or administrative position or on behalf of a public international body.*

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

Surname of 1st **dependent child**:

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

Date of birth (DDMMYYYY): / /

Sex: Male ◯ Female ◯

Social security number/CFE number: Check digit:

Date of entitlement for the CFE (DDMMYYYY): / /

If you are applying for French Social Security/CFE top-up insurance

Surname of 2nd **dependent child**:

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

Date of birth (DDMMYYYY): / /

Sex: Male ◯ Female ◯

Social security number/CFE number: Check digit:

Date of entitlement for the CFE (DDMMYYYY): / /

If you are applying for French Social Security/CFE top-up insurance

1

Surname of 3rd **dependent child**:

First names of 3rd **dependent child**:

Date of birth (DDMMYYYY): / /

Sex: Male ◯ Female ◯

Social security number/CFE number: Check digit:

Date of entitlement for the CFE (DDMMYYYY): / /

If you are applying for French Social Security/CFE top-up insurance

Surname of 4th **dependent child**:

First names of 4th **dependent child**:

Date of birth (DDMMYYYY): / /

Sex: Male ◯ Female ◯

Social security number/CFE number: Check digit:

Date of entitlement for the CFE (DDMMYYYY): / /

If you are applying for French Social Security/CFE top-up insurance

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PRINCIPAL INSURED | **Address for delivery of correspondance**

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 ◯

3

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 ◯ **School/Institution** ◯ **Corporate** ◯ **Name of company/institution:**

Title: Mrs ◯ Mr ◯

Surname:

First names:

Address:

Postcode: City:

State/Region/Land/County:

Country:

Telephone: + / Cell phone: + /

Email:

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TYPE OF COVERAGE AND REIMBURESEMENT METHOD FOR MEDICAL EXPENSES

Type of coverage:

◯ From the 1st euro

◯ As a top-up to the CFE

◯ As a top up to French Social Security

Reimbursement method for medical expenses:

◯ Bank transfer to a bank account in France. In this case, please send us details of your bank account.

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

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

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

BENEFICIARIES IN THE EVENT OF DEATH FOR PERSONAL ACCIDENT BENEFIT

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Principal insured: I name as benefi ciary (or beneficiaries) in the event of my death:

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

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

....

....

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

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

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

....

....

In the absence of a precise designation of the benefi ciaries, the death benefi t 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.

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Choice of effective date: __ __ / __ __ / __ __ __ __ (1st or 16th of the month only)

Maximum effective date: 16 September 2022 (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	Credit or debit card*	Bank transfer*	Cheque*
		*If I choose any of these three payment methods it is my responsibility to ensure payment is made for each instalment		
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 quarter or €80 per year	◯ €20 per quarter or €80 per year	◯ €20 per quarter or €80 per year
Monthly	◯			

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▸ Calculating the annual premium

Annual premium, principal insured:	€ ____ , __	A
Annual premium, spouse:	€ ____ , __	B
Annual premium, children:	€ ____ , __	C
Annual instalment fees (including membership fee of the Association des Assurés APRIL: €2):	+ € 20 , 00	D
Annual membership fees (unless you are paying by SEPA direct debit or annually):	+ € __ , __	E
Total premiums* for 12 months: A + B + C + D + E:	€ ____ , __	F

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

Total amount of first premium: € ____ , __

If you want your policy to take effect on the 16th of the month, you should divide the first monthly premium by two. The first premium is a pro rata amount of the annual premium which is valid from the effective date of your policy until 30/09/2022. When calculating your premium, remember to take into account the payment frequency selected.

▸ Paying the first premium:

◯ by cheque **payable to APRIL International Care France** or bank transfer.

◯ by credit or debit card (Eurocard-Mastercard and Visa only)

Please provide your card details using the box on page 13

Paperless premium notices are available by email or in your online Customer zone.

SIGNATURE OF THE APPLICATION

I hereby apply for membership of the Association des Assurés APRIL under their agreements with Axéria Prévoyance for medical expenses benefit (plan no. A3MCSLDFDS1E2013) and for repatriation assistance, Exam insurance benefit insured by CHUBB European Group SE (plan no. FRBOTA11959) for the insured listed on the Application form. I have read the Association's statutes and regulations (available to download at: https://www.associationdesassuresapril.fr/l-association/l-association-en-bref).

I am applying for insurance with Solucia PJ under this policy for legal assistance (contract no. 10006609) and CHUBB European Group SE for Personal liability private capacity, internships and tenant's liability (contract no. FRBOTA13138).

The provisions of these agreements describing the benefits and how they apply and the formalities to be completed in the event of a claim are set out in the General Conditions ExS Cov. I confirm that I received a copy of this document when joining the plan, have read it, in particular my right to cancel the insurance as well as the terms and conditions of APRIL International Care France's handling of my insurance cover, accept its provisions and have retained a copy. On joining the plan, I received and familiarised myself with the Insurance Product Information Document ExSCovIPID and a copy of the benefits schedule, have read it, accepted its provisions and retained a copy. My membership will be renewed by tacit renewal on 1 October each year, for a period of one year, with a maximum term of 6 years.

If my insurance cover is subsequently amended, I accept that the General conditions applied will be those outlined above.

The personal data collected by APRIL International Care France is essential for the processing of the application for insurance.

It is governed by (EU) Data Protection Regulation No. 2016/679 of 27th April 2016.

By signing the application form, data subjects give their consent to the processing of their personal data.

This data is processed electronically for the purposes of studying, arranging and managing the insurance cover, the implementation of legal and/or regulatory obligations and the improvement of products and services.

APRIL International Care France has also implemented a procedure to combat insurance fraud. This may result in the application of civil, financial and/or criminal sanctions and inclusion on a list of persons presenting a risk of fraud.

To meet its legal obligations, APRIL International Care France has also implemented a monitoring procedure the purpose of which is to combat money laundering and the financing of terrorism, and the application of financial penalties.

This data is intended for the insurer and APRIL International Care France in their capacity as processors of the data.

Depending on the purpose of the processing, it may also be passed on to their partners, subcontractors and the public authorities in accordance with the law.

To help us measure and improve our quality of service, letters, faxes, emails and telephone conversations sent or made to APRIL International Care France may be analysed, recorded and processed electronically for which purpose your personal data may be passed on only to APRIL International Care France , its partners and subcontractors.

Personal data may also be used for commercial purposes by APRIL unless the data subject chooses to opt out by making the request to APRIL International Care France by sending an email to info.expat@april-international.com or a letter to the address shown below, or directly from the Customer Zone at https://fr.april-international.com/en/espace-clients.

Personal data is stored for the duration required for the purpose of its processing and in accordance with the statutory time limits.

It may be transferred outside the European Union. These transfers are subject to data protection and security rules. Information about the transferred data and the recipients will be provided by APRIL International Care France on request from the address shown below.

In accordance with (EU) Data Protection Regulation No. 2016/679 of 27th April 2016, data subjects have the right to access their personal information, have it corrected, restricted, deleted and, for legitimate reasons, opt out of this information being processed. They also have the right to portability of their data and the right to set guidelines with respect to what happens to their data after their death, except in cases where the regulations do not allow these rights to be exercised.

As the statutory health insurance scheme receives a certain amount of information, these persons may at any time and in writing opt out of copies of their Statutory Scheme statements being sent to APRIL International Care France.

To exercise one or more of these rights, a copy of an identity document should be sent to the APRIL Data Protection Officer by post at the following address: APRIL International Care France, Service Courrier, 1 rue du Mont, CS 80010, 81700 Blan, FRANCE or by email to dpo.AICF@april.com.

In accordance with the provisions of Article L561-45 of the French Monetary and Financial Code, persons affected by monitoring of their data may exercise their right of access by applying to the French Data Protection Authority, Commission Nationale Informatique et Libertés - 3 Place de Fontenoy - TSA 80715 - 75334 PARIS CEDEX 07.

Complaints relating to the processing of personal data should be made to the French Data Protection Authority, Commission Nationale Informatique et Libertés, on its website www.cnil.fr or by post at the address shown above.

In application of the provisions of Articles L223-1 onwards of the French Consumer Code, you are informed that data subjects may register on the cold-calling opt-out list either by post, by writing to: OPPOSETEL - Service BLOCTEL - 6, rue Nicolas Siret - 10300 TROYES or by visiting the OPPOSETEL website at the following address: bloctel.gouv.fr. This service is free of charge.

SIGNATURE OF THE APPLICATION (continued)

Under no circumstances does inclusion on this list prohibit the insurer and APRIL International Care France from contacting them by telephone within the framework of existing contractual relations.

I undertake to inform all persons covered by this membership application of their enrolment in the plan and to pass on to them the information provided to me by APRIL International Care France in respect of the processing of their personal data and the rights to which they are entitled.

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

I accept that the reimbursement of or compensation for expenses incurred as a result of illness, maternity or an accident cannot exceed the amounts which were invoiced to me. I understand that APRIL International 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.

If I have taken out insurance as a top-up to the CFE/French Social Security, my Social Security centre will be sent a certain amount of information. I may opt out in writing and at any time of the forwarding by Social Security of copies of my Social Security statements to APRIL International Care France.

If I have taken out insurance cover from the 1st euroeuro/dollar, I agree to return to APRIL International Care France any amounts paid to me by any Social Security body and/or any other healthcare or death & disability insurance provider.

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.

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

Signed in (town or city) ____________________ Date (DDMMYYYY) __ __ / __ __ / __ __ __ __

Signature(s) of the principal insured and insured spouse preceded by the word **"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":** 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.

We are delighted you want to become a member.

These are the steps to follow to apply for membership of the plan:

1

Complete 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.

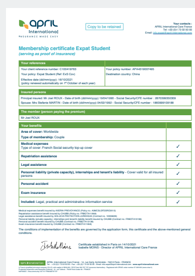
2

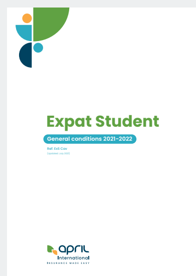
We process your application as soon as it arrives.

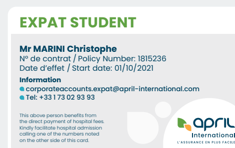
3

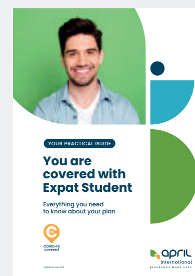
You will be sent:

- votre Certificat d'adhésion valant attestation d'assurance,
- 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.









HEALTH QUESTIONNAIRE

This Health questionnaire is valid for 6 months.

For example, if you want your policy to start on 01/07/2022, you can sign the questionnaire between 01/01/2022 and 30/06/2022.

Each insured person must complete a Health questionnaire.
If the policy covers more than one person, please photocopy 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 havi ng 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 Care'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's Medical Examiner at the above address.

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

DATE OF BIRTH: |__|__|____| HEIGHT: |___| cm WEIGHT: |___| kg

	Question	Answer	Details
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	Ilness(es): .... Date of diagnosis: |__|__|____| Treatment: .... Start of treatment: |__|__|____| Progress: ....
2	Do you have or have you ever had a congenital and/or hereditary condition or a total or partial disability?	◯ YES ◯ NO	Reason: .... Start: |__|__|____| End: |__|__|____| Location or name of the illness: .... Percentage of permanent incapacity or disability: |__| %
3	During the last 5 years, have you been absent from work/ cursus for more than 15 consecutive days due to illness or accident?	◯ YES ◯ NO	Reason: .... Start: |__|__|____| End: |__|__|____|
4	During the last 10 years, have you been hospitalised or undergone a surgical procedure (excluding surgery on wisdom teeth or tonsils and appendicitis)?	◯ YES ◯ NO	Date: |__|__|____| Reason(s) for admission: .... Length of stay: .... Results: .... Prescribed treatment: .... Progress: ....

HEALTH QUESTIONNAIRE (continued)

5	**Have you ever been tested for one of the following diseases:**		
	a) **HBV** (hepatitis B)?	◯ YES ◯ NO	Date: __ __ / __ __ / __ __ __ __ Resultat: ◯ positive ◯ negative
	b) **HCV** (hepatitis C)?	◯ YES ◯ NO	Date: __ __ / __ __ / __ __ __ __ Resultat: ◯ positive ◯ negative
	c) **HIV** (AIDS)?	◯ YES ◯ NO	Date: __ __ / __ __ / __ __ __ __ Resultat: ◯ positive ◯ negative
6	Is it planned over the 6 coming months for you to have any medical examinations (laboratory tests, medical imaging, endoscopy or any other medical examination), consult a specialist or undergo any medical or surgical treatment?	◯ YES ◯ NO	Reason(s): ...... Type of examination or treatment: ...... Expected date(s): __ __ / __ __ / __ __ __ __
7	Is it planned over the 12 months following theeffective 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	Reason(s): ...... Expected date(s): __ __ / __ __ / __ __ __ __

Details if you answered YES to any of the questions:
To help us process your application, please provide additional details about your health condition.

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ADDITIONAL INFORMATION ......

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 (DDMMYYYY) __ __ / __ __ / __ __ __ __

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:

SEPA direct debit mandate

(to be completed if selecting payment by direct debit)

april International

Your quote/policy reference:

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 paymen* (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

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 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 simple letter 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: **Expat Student Ref. ExS Cov**

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, 2 and 3.

B. Choose the reimbursement method for medical expenses 4.

C. Please designate the beneficiary/beneficiaries in case of death for personal accident cover 5.

D. Enter the effective date on which you want your policy to start 6.

E. Calculate your premium and indicate your chosen payment method 7.

F. Date and sign your Application in Section 8.

G. Fill in and date and sign the Health questionnaire(s) 9.

H. For the payment of your first premium, you can:
   - enclose a cheque in euros payable to APRIL International Care France, ***OR***
   - provide your credit/debit card details on page 13 of the Application form, ***OR***
   - arrange for a bank transfer (in this case, attach a copy of the transfer order).

   For the following premiums, please fill in the SEPA direct debit mandate if you wish to make payments by direct debit.

I. Enclose a photocopy of a current student card or, school attendance certificate or a copy of your contract with the host family for au pair placements for the principal insured, and their spouse where applicable.

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 elected and the effective date of your policy.

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

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Any reproduction of any kind, either partial or total, of the said elements and text is prohibited and will result in prosecution. July 2021.

APRIL International Care France Head Office:

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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.
Product insured by Axéria Prévoyance (health care benefit n°A3MCSLDFDS1E2013 and A3MCSLDFDSRO2013),
and Chubb European Group SE (for the other benefits).
NAF6622Z - Intra-community VAT N° FR603009707727