[**La Mobilité**] individuals

Valid across the Europe-Mediterranean zone

Application form 2010
Euro Cover +

[solutions] for **europatriates and impatriates**

Insurance cover for europatriates and impatriates up to age 70 in the Europe-Mediterranean zone

april
MOBILITÉ

Application form

Send to: **APRIL Mobilité - Service Adhésion Remboursement**
110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

Points to remember

- It will help us to process your application more efficiently if you:
  - complete the forms using a black biro
  - complete the forms in CAPITAL LETTERS, one letter to each box: S M I T H
  - mark the appropriate box with a cross
  - (if you make a mistake, completely black out the wrong box and put a cross in the right one)

- If you send your application by fax, don't forget to send both sides of the form (Application form, Health questionnaire) and direct debit authorisation and bank details (if you have selected this payment method).

  Important: in order to complete your application, the originals of the Application form, the Health questionnaire, the direct debit authorisation and bank details (if you have selected this payment method) must be sent to APRIL Mobilité within the next few days.

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

1 Title of **principal insured** : ☐ Mrs ☐ Miss ☐ Mr

Surname of **principal insured**:

First names of **principal insured**:

Date of birth: _ _ / _ _ / _ _ _ _ (m m / d d / y y y y)

Home country:

Country of residence abroad:

Occupation:

E-mail:

Providing an email address will allow you to receive information on your reimbursements.

2 Marital status of **spouse** or **common-law spouse**: ☐ Mrs ☐ Miss ☐ Mr

Surname of **spouse** or **common-law spouse**:

First names of **spouse** or **common-law spouse**:

Date of birth: m m / d d / y y y y

Home country:

Country of residence abroad:

Occupation:

3 Surname of **1st dependent child:**

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

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

4 Surname of **2nd dependent child:**

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

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

5 Surname of **3rd dependent child:**

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

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

If the insured have more than 3 dependent children, please photocopy page 3 and fill it out.

PRINCIPAL INSURED — Address for delivery of correspondence

Street number: Street type (ave., st., blvd,…):

Street name:

Street name (continued):

Postcode:

Town or City:

State/Region/Canton/Land/County:

Country:

Telephone: / / / / / * *if outside France*

My language of choice of correspondence is: ☐ french ☐ english

MEMBER — Who is paying the premium

Required only if the principal insured is not paying the premium

Corporate ☐ Name of company:

Individual ☐

Title: ☐ Mrs ☐ Miss ☐ Mr

Surname:

First names:

Date of birth: / / *m m / d d / y y y y*

Street number: Street type (ave., st., blvd,…):

Street name:

Street name (continued):

Postcode:

Town or City:

State / Region / Canton / Land / County:

Country:

Telephone: / / / / / * *if outside France*

E-mail :

Providing us with an email address means we can send you information on your policy.

While you are insured with us, please visit our extranet service via the "Espace Particulier" link at www.aprilmobilite.com to amend or update your contact details.

CHOICE OF BENEFITS AND LEVEL OF COVER:

1 Repatriation assistance

☐ Individual membership ☐ Family membership

☐ Home country - Europe-Mediterranean ☐ Home country - Worldwide

The option selected will depend on the location of your home country. Annual premium (all taxes included): € A

2 Medical expenses

☐ Individual membership ☐ Family membership

The level of the family premium is determined by the age of the eldest person.

☐ Option 1 ☐ Option 2 ☐ Option 3

☐ Excess per item € 0 ☐ Excess per item € 20 ☐ Excess per item € 40

☐ Option "Permanent extension of medical cover to the home country"

This option can only be selected if the insured's home country is located in the Europe-Mediterranean zone.

Annual premium (all taxes included): € . B

For medical expenses, you can be reimbursed by:

☐ cheque in euros sent to the address of your choice. You will have no bank charges to pay,

☐ bank transfer to a bank account in France. You will have no bank charges to pay, please send us details of your bank account,

☐ bank transfer to a foreign account in any country and in any currency. International bank details are required including the IBAN number, SWIFT code, your bank's address, routing number or sort code and an ABA routing number for the US. Please specify your choice of currency. You will pay bank charges on any payment over € 75.

3 Personal liability *(must be combined with another type of cover under the policy)*

→ **Single premium per policy**

Annual premium (all taxes included): € C

4 Death and total and irreversible loss of autonomy

→ **Individual membership only**

Depending on the level of benefit selected, certain medical formalities may be required. Please refer to page 10 of the brochure.

Principal insured

Amount of cover requested (between € 20,000 and € 400,000): €
Amount doubled in case of death by accident

Annual premium (all taxes included): € . D

Spouse/Common-law spouse

Amount of cover requested (between € 20,000 and € 400,000): €
Amount doubled in case of death by accident

Annual premium (all taxes included): € . E

Name of beneficiaries

Principal 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, to my children living, to be born or represented as such; third, equally, to my ascendants and fourth to my other heirs

☐ Other beneficiary: Surname: .... First names: ....

Date of birth: d d m m y y y y Place of birth: ....

Spouse/Common-law 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, to my children living, to be born or represented as such; third, equally, to my ascendants and fourth to my other heirs

☐ Other beneficiary: Surname: .... First names: ....

Date of birth: d d m m y y y y Place of birth: ....

5 Sick leave from work

(must be combined with death and total and irreversible loss of autonomy cover ; the amount of the daily allowance depends on the level of death benefits you have selected → for example, to receive € 20 per day, you must have selected death benefit of at least € 20,000)

→ **Individual membership only**

Depending on the level selected, certain medical formalities may be required. Please see page 11 of the brochure.

Principal insured

Gross annual salary*: €

Amount of daily allowance requested (between € 20 and € 140): €

Excess: ☐ 30 days ☐ 60 days

Corresponding death benefits: €

Annual premium (all taxes included): € . F

Spouse/Common-law spouse

Gross annual salary*: €

Amount of daily allowance requested (between € 20 and € 140): €

Excess: ☐ 30 days ☐ 60 days

Corresponding death benefits: €

Annual premium (all taxes included): € . G

* *compulsory fields*

Choice of start date: 01 / __ / 2010

(subject to acceptance of your application and, at the earliest, the first day of the month following receipt of the Application form)

Payment of the premium

Select a method of payment of the premium	Tick your chosen payment method			
	Direct debit from a French bank account	Debit card*	Bank transfer*	Cheque*
Annual	☐	☐	☐	☐
Twice yearly	☐	☐ € 23 per semester	☐ € 23 per semester	☐ € 23 per semester
Quarterly	☐	☐ € 23 per quarter	☐ € 23 per quarter	☐ € 23 per quarter
Monthly	☐	* If I choose any of these three payment methods it is my responsibility to ensure payment is made for each instalment		

Calculation of the premium

Total annual premium (all taxes included): A + B + C + D + E + F + G: € ____ . __ H

Annual membership fee in addition to cover selected: + € 30 . 00 I

Instalment charges of € 23 if payment is twice yearly (2 x € 23) or quarterly (4 x € 23), unless payment is by direct debit: + € __ . __ J

Total of annual premium (all taxes included) + annual membership fee + instalment charges: H + I + J: € ____ . __ K

Twice yearly premium (all taxes included): K / 2: € ____ . __

Quarterly premium (all taxes included): K / 4: € ____ . __

Monthly premium (all taxes included): K / 12: € ____ . __

The Euro Cover + policy is renewed automatically every year on 1st January for one year.The premiums may be modified on this date depending on the claims history of the policy.The first payment will be pro-rated for the quarter, semester or year (from 1st January to 31st December).

Example

For a policy with a start date of 1st September and a twice yearly premium of € 1,800, a payment of € 1,200 would be due in the first year.The first payment of the following year would be € 1,800 plus any increase in premium effective on 1st January.

☐ I will pay my first premium by cheque, postal order in euros **payable to APRIL Mobilité** or by bank transfer or direct debit from a French bank account (please send us your bank details and complete the attached direct debit authorisation form).

☐ I will pay my first premium payment by credit card (only Eurocard-Mastercard and Visa are accepted):

☐ Eurocard-Mastercard ☐ Visa

Card number: ____ / ____ / ____ / ____

Expiry date: __ / __

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

Cardholder:

☐ I will make future payments by cheque/bank transfer/debit card. I understand that is is my responsibility to make the payments as each instalment becomes due.

☐ I will make future payments by direct debit from a French bank account. Please send us your bank details and complete the attached direct debit authorisation form.

Signature of the application

I hereby apply for membership of the Association of APRIL Mobilité insured under their agreements with Axéria Prévoyance and ACE Europe for the insured listed on the Application form.
I have read the Association's statutes and regulations.

By choosing personal liability (private capacity) cover, I am applying for insurance with Gan Eurocourtage IARD under the policy.

I have read the General conditions and booklet Ec 2010 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 Mobilité'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 have been informed that the information requested is required in order to process my application and that these details will be held electronically by APRIL Mobilité, the insurer or their agent for the requirements of my insurance cover.

Under the Act of 6th January 1978, I have the right to access and, if necessary, rectify any personal information held on file by writing to APRIL Mobilité, 110 avenue de la République, CS 51108, 75127 Paris Cedex 11, FRANCE. APRIL Mobilité has the right to utilise certain administrative information and to share it with associated businesses who may use it to make me aware of new products or services. A list of these companies is available on request.

Under the Act of 6th January 1978, I have the right to prevent my details being passed on in this way by writing to APRIL Mobilité at the above address. Postal charges will be refunded.

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

I declare either that I am not insured under the statutory healthcare scheme of my main country of residence or that my contributions to that scheme are up to date.

I understand that being covered under the current policy does not exempt me from paying contributions to any statutory scheme under which I may be insured.

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 the present policy.

In .... *Date* ....

SIgnature of the principal insured and insured spouse or common-law 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"*:

Health questionnaire

Validity of the health questionnaire: 6 months

Example: if you would like your policy to start on 01/07/2010, you can sign this questionnaire between 01/01/2010 and 30/06/2010.

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.

QUESTIONS:

1	Height
2	Weight
3	Are you currently on partial or total sick leave from work due to illness or accident?
4	Within the **last 10 years**, have you: *a)* undergone surgery? *b)* undergone laser treatment, chemotherapy or radiation therapy?
5	Within the **last 5 years**, have you had an illness or an accident which resulted in: *a)* more than one month's sick leave from work? *b)* more than one month's medical treatment?
6	Within the **last 5 years**, have you consulted a doctor for: *a)* nervous conditions (chronic fatigue, anxiety, depression)? *b)* back complaints (back pain, sciatica, slipped disc)? *c)* arthritis and/or rheumatism (hip, knee, shoulder…)?
7	Do you suffer from any disorder or illness requiring regular medical supervision or treatment?
8	Have you been tested for HBV (Hepatitis B)? If you answered "Yes" to this question,were the results positive? ***Date of the test:***
8 Bis	Have you been tested for HCV (Hepatitis C)? If you answered "Yes" to this question,were the results positive? ***Date of the test:***
8 Ter	Have you been tested for HIV (AIDS)? If you answered "Yes" to this question,were the results positive? ***Date of the test:***
9	Do you have a disability which entitles you to benefits?
10	Will you undergo any diagnostic test **over the next 6 months** (lab tests, scans, endoscopy…) and/or have a consultation with a specialist and/or any treatment or surgery?
11	It is planned for you to be hospitalised for more than 48 hours for any reason whatsoever **during the 12 months following the start date of your insurance cover** (removal of tonsils, knee surgery, removal of cyst, childbirth...)?
12	Within the **last 12 months**, have you had: *a)* more than 3 periods of sick leave of any duration? *b)* specialist tests (other than routine screening) such as lab tests, scans, endoscopy…?
13	Do you have, or have you ever had 100% cover from Social Security for a long-term complaint (with no contribution from you towards costs)?
14	Do you want your responses to this Health questionnaire to remain confidential?

Confidential

Any medical information you provide is held in strict confidence. Detailed answers will help us process your application promptly. To ensure your responses remain confidential, please send the health questionnaire and all supporting documentation in a sealed envelope for the attention of the APRIL Mobilité's Medical Examiner.

Some of the medical information you provide may be processed electronically for the use of the APRIL Mobilité's Medical Examiner. Under the act of 6th January 1978, you have the right to access and, if necessary, rectify any personal information held on file by writing to the Medical Examiner, APRIL Mobilité - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

	Principal insured	Spouse or Common-law spouse	1st dependent child	2nd dependent child	3rd dependent child
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO
	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO
	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO
	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO
	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

For new cover after the age of 60, a medical visit at your expense is required and a medical report provided by APRIL Mobilité must be completed.

If you wish your answers to remain confidential, make a copy of the blank Health questionnaire, fill it out and send it 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 Mobilité - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Further details if the response to one of the questions is YES (other than question 14):

To help us process your application, please provide further details regarding the events surrounding the illness or accident and any consequences resulting from it.

Example:

If you have had an operation to remove your appendix and answered **YES** to question 4, you would write in the space below: 4, appendix removed, 2003, 3 days in hospital. No further treatment required.

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.

In .... *Date* ....

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

Signature of the insured spouse or common-law spouse preceded by the words *"I have read, understood and accepted the policy document"*:

Signature(s) of the insured dependent child(ren) over 18 preceded by the words *"I have read, understood and accepted the policy document"*:

Your Insurance Advisor + APRIL Mobilité Code:

I

Direct debit authorisation form

National Issuer Number 004082

I hereby authorise my bank to effect transfers from my account, if adequate funds are available, on the instructions of the organisation named below. In the event of a disputed transaction I have the right to cancel the order by instructing my bank to do so. I will then settle the outstanding amount with the creditor.

Name and address of the creditor: APRIL Mobilité - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

Surname, first names and address of account holder:

Surname of account holder:

First names of account holder:

Street number: Street type (ave., st., blvd,…):

Street name:

Street name (continued):

Postcode:

Town or City:

Country:

Account to be debited:

Sort code: Branch code:

Account number: Transaction code:

Name and address of the bank to be debited:

Name:

Street number: Street type (ave., st., blvd,…):

Street name:

Street name (continued):

Postcode:

Town or City:

Country: F R A N C E

Date: .... *Signature:* ....

Please send this form to APRIL Mobilité and enclose details of your bank, postal or savings account.

APRIL Mobilité **by your side**

Specialising in insurance for people living outside their home country, APRIL Mobilité provides simple and innovative health-care and life insurance products for individuals, businesses and the self-employed. Our products meet the needs of travellers, expatriates, impatriates, employees on assignment abroad and students. For more than 30 years, APRIL Mobilité (formerly AIPS) has been wholly committed to total client satisfaction by means of our clear and easy to understand products supported by a range of services and top quality management of your insurance choices.

Personal and Group Insurance for expatriates, impatriates and travellers **www.aprilmobilite.com**

APRIL, **tailor-made insurance solutions**

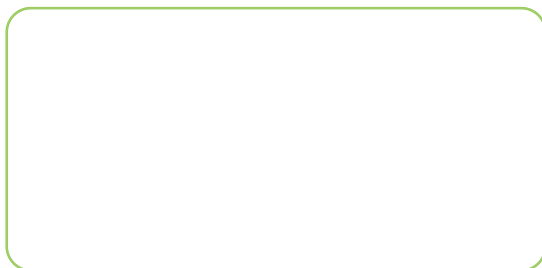
April provides a wide range of insurance solutions meeting the needs of individuals, professionals and businesses across all areas of insurance.

To find out more about our insurance solutions **www.aprilgroup.com**

APRIL GROUP, **changing the face of insurance**

From our beginnings in 1988, the APRIL GROUP has been committed to changing the face of the insurance industry by ensuring that the client is always at the heart of our business.
Today, more than **3 million people** know they can count on our **3,500 employees** and **72 companies** to protect their goods and families day after day.

For more information, contact your insurance consultant:



APRIL MOBILITÉ MEMBER OF APRIL GROUP

Headquarters
110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE
Tel: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90
E-mail: info@aprilmobilite.com - Internet:www.aprilmobilite.com

Public limited company with capital of € 200,000 - Registered with Companies House in Paris under number 309 707 727
Insurance broker - Registered with ORIAS (Organisation for the registration of insurance brokers) under number 07 008 000 (www.orias.fr)
Regulatory body for Insurance Activities - 61, rue Taitbout 75436 Paris cedex 09

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