



Valid in all
countries
visited

Application form 2010

Magellan

[Insurance solutions] for **globetrotter and short-term expatriates**



***Personal insurance
for globetrotter
and short-term expatriates
up to age 75,
from € 55 per month***

Application form

Send to: **APRIL Mobilité - Service Conseil Client - 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 and Health questionnaire), direct debit authorisation (if paying by monthly instalments). You must also post the originals of the documents and the direct debit authorisation (if paying by monthly instalments) to APRIL Mobilité within the following few days.

INSURED	Person to be insured
1 Title of principal insured : <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Mr	
Surname of principal insured : <input type="text"/>	
First names of principal insured : <input type="text"/>	
Date of birth: <input type="text"/> / <input type="text"/> / <input type="text"/> <i>dd/mm/yyyy (upper age limit of 74)</i>	
Home country: <input type="text"/>	
Country of residence abroad: <input type="text"/>	
Occupation: <input type="text"/>	
Status of the insured: <input type="checkbox"/> Student <input type="checkbox"/> Employee <input type="checkbox"/> Self-employed <input type="checkbox"/> Language course <input type="checkbox"/> Working Holiday Programme <input type="checkbox"/> Other	
French Social Security number/CFE*: <input type="text"/> Check digit: <input type="text"/>	
<i>* If top-up cover to French Social Security or the CFE has been selected.</i> E-mail*: <input type="text"/> <i>* Providing an email address will allow you to receive information on your reimbursements.</i>	
<hr/> 2 Marital status of spouse or common-law spouse : <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Mr	
Surname of spouse or common-law spouse : <input type="text"/>	
First names of spouse or common-law spouse : <input type="text"/>	
Date of birth: <input type="text"/> / <input type="text"/> / <input type="text"/> <i>dd/mm/yyyy</i>	
Home country: <input type="text"/>	
Country of residence abroad: <input type="text"/>	
Occupation: <input type="text"/>	
French Social Security number/CFE*: <input type="text"/> Check digit: <input type="text"/>	
<i>* If top-up cover to French Social Security or the CFE has been selected.</i>	

3 Surname of 1st dependent child:

First names of 1st dependent child:

Date of birth: / / dd/mm/yyyy Sex: Male Female

4 Surname of 2nd dependent child:

First names of 2nd dependent child:

Date of birth: / / dd/mm/yyyy Sex: Male Female

5 Surname of 3rd dependent child:

First names of 3rd dependent child:

Date of birth: / / dd/mm/yyyy 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 correspondance is: french english

POLICYHOLDER = WHO IS PAYING THE PREMIUM Required only if the principal insured is not paying the premium

Individual

Corporate Name of company:

Title: Mrs Miss Mr Date of birth: / / dd/mm/yyyy

Surname:

First names:

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

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.

Beneficiary in the event of death

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

- My surviving spouse on condition that where 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: |_|_|_|_|_|_|_|_|_|_| 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 where 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: |_|_|_|_|_|_|_|_|_|_| Place of birth:

1st dependent child: I name as beneficiary (or beneficiaries) in the event of my death:

- My surviving spouse on condition that where 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: |_|_|_|_|_|_|_|_|_|_| Place of birth:

2nd dependent child: I name as beneficiary (or beneficiaries) in the event of my death:

- My surviving spouse on condition that where 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: |_|_|_|_|_|_|_|_|_|_| Place of birth:

Beneficiaries in the event of death of the dependant childs are the principal insured, his spouse/common-law spouse and their heirs in equal parts.

If the insured have more than 3 dependant children, please photocopy page 4 and fill it out.

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. In this case, 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, SWFT 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 have no bank charges on any payment over € 75.

Period and level of cover

I, the undersigned, request cover under the Magellan policy from: |_|_|_| / |_|_| / |_|_|_|_|_|

to: |_|_| / |_|_| / |_|_|_|_|_| for a duration of: |_|_|, |_| months

Are you renewing an existing policy? NO YES Customer Number: C |_|_|_|_|_|_|_|_|

Level of cover selected:

- either** **option 1** → reimbursement from the 1st euro spent (for stays of between 2 weeks and 12 months)
- either** **option 2** → reimbursement as a top-up to: Social Security (only available for stays of up to 3 months)
- the CFE (for stays of 3 months or more)

Subscription: Individual Family

The level of the family premium depends on the age of the eldest person.

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.

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

QUESTIONS:

- 1 Are you currently on partial or total sick leave from work due to illness or accident?
- 2 Within **the last 10 years**, have you:
 - a) undergone surgery?
 - b) undergone laser treatment, chemotherapy or radiation therapy?
- 3 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?
- 4 Within **the last 5 years**, have you consulted a doctor for:
 - a) emotional disorders (chronic fatigue, anxiety, depression)?
 - b) back complaints (back pain, sciatica, slipped disc)?
 - c) arthritis and /or rheumatism (hip, knee, shoulder...)?
- 5 Do you suffer from any disorder or illness requiring regular medical supervision or treatment?
- 6 Have you been tested for HBV (Hepatitis B)?
If you answered "Yes" to this question, were the results positive?
Date of the test:
- 6b Have you been tested for HCV (Hepatitis C)?
If you answered "Yes" to this question, were the results positive?
Date of the test:
- 6c Have you been tested for HIV (AIDS)?
If you answered "Yes" to this question, were the results positive?
Date of the test:
- 7 Do you have a disability which entitles you to benefit?
- 8 Is it planned, over **the next 6 months**, for you to undergo any diagnostic tests (lab tests, scans, endoscopy...) and/or have a consultation with a specialist and/or any treatment of surgery?
- 9 Is it 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...)?
- 10 Within **the last 12 months**, have you had :
 - a) more than three periods of sick leave of any duration?
 - b) special tests (other than routine screening) such as lab tests, scans, endoscopy, ... ?
- 11 Do you want your responses to this Health questionnaire to remain confidential?

To ensure your responses remain confidential, please send the health questionnaire and all supporting documentation in a sealed envelope for the attention of APRIL Mobilité Medical Examiner.

Some of the medical information you provide may be processed electronically for the use of 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	1 st dependant child	2 nd dependant child	3 rd dependant child
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Further details if the response to one of the questions is yes (other than question 11):

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 2, you would write in the space below: 2, appendix removed, 2003, 3 days in hospital. No further treatment required.

Details

THE INSURERS 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 excluded anything which might mislead the insurers of the Magellan policy.

In date

Signature of the principal insured preceded by the words
"Read, understood and accepted":

Signature of the spouse/common-law spouse preceded by the words
"Read, understood and accepted"

Signature of the dependent child preceded by the words
"Read, understood and accepted"

Your Insurance Advisor + APRIL Mobilité Code

I

Direct debit authorisation form

National Issuer Number 004082

(To be completed if monthly payments have been selected)

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 healthcare 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

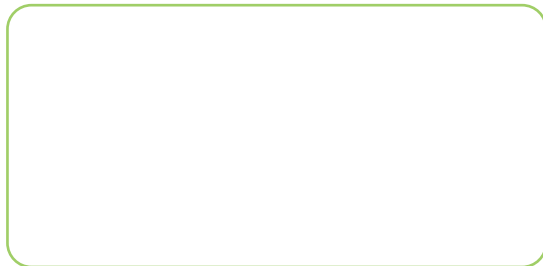
www.aprilgroup.com

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

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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

