



Application form 2010

Welcome Cover

[Insurance solutions] for short-term **impatriates in France**



***Personal insurance for
short-term impatriates in France
up to age 79,
from € 61 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 Simplified health questionnaire). In order to complete your application, you must also post the originals of the documents to APRIL Mobilité within the following few days.

INSURED		Foreign national to be insured	
Title:	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Mr <input type="checkbox"/>
Surname:			
First names:			
Date of birth:	dd/mm/yyyy (upper age limit of 79 for option 2; 64 for option 1)		
Home country:			
Country to be visited:	F R A N C E		
If French Overseas Departments and Regions, please specify:			
Status of the insured:	Student <input type="checkbox"/>	Employee <input type="checkbox"/>	Self-employed <input type="checkbox"/>
E-mail:			
<i>Providing an email address will allow you to receive information on your reimbursements.</i>			

INSURED		Address for delivery of correspondence	
<i>If you would like correspondence from us to be sent care of another person, please let us know the name of the official owner/occupier at that address (the name on the letter box)</i>			
Name of the person:			
Street number:	Street type (ave., st., blvd,...):		
Street name:			
Street name (continued) :			
Postcode:			
Town or City:			
Country:			
State/Region/Canton/Land/County:			
Telephone:	if outside France		
My language of choice of correspondence is:	french <input type="checkbox"/>	english <input type="checkbox"/>	

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 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.

Beneficiary in the event of death

My surviving spouse on condition that 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: / / dd/mm/yyyy

Place of birth:

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 Welcome Cover policy from: / / to: / /

for a duration of: , months (minimum 15 days; maximum 12 months, duration limited to a maximum of 3 months for the 65-79 age group)

Level of cover selected:

either **Option 1** → illness or accident → Premium: €

either **Option 2** → hospital costs in the event of an accident only → Premium: €

Payment

Payment must be made for the whole period of insurance. Payment in instalments is not accepted. In the event of cancellation, and if a Policyholder certificate has been issued, there will be a charge of € 35. Applications will be rejected unless they include full payment of the premium by cheque made payable to **APRIL Mobilité** or by credit/debit card.

You have chosen to pay:

by **cheque**, please make it payable to **APRIL Mobilité**.

by **debit/credit card**, please enter your card details below:

Only Eurocard-Mastercard and Visa cards are accepted: Eurocard-Mastercard Visa

Card number: / /

Expiry date: /

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

Name of cardholder:

I hereby apply for cover under the Welcome Cover insured by Gan Eurocourtage Vie, Gan Eurocourtage IARD and ACE EUROPE for myself and the beneficiaries listed on the Application form.

I have read the General conditions and booklet Wc 2010 outlining the details of my insurance cover. This information is available from my insurance advisor. 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 understand that cover under the present policy does not exempt me from paying contributions to any state scheme to which I may belong.

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 Welcome Cover policy.

I agree to pay APRIL Mobilité any reimbursements made to me by Social security or any private healthcare insurer.

In date

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

Signature of the policyholder (if different)
preceded by the words "Read, understood and accepted";

For children under 18, the Application form must be signed by the father, mother or legal guardian.

Simplified health questionnaire

Validity of the simplified health questionnaire: 6 months.

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

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.

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.

<p>1 - Do you suffer from any disorder or illness requiring regular medical supervision or treatment?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>2 - 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...)?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>3 - Do you want your responses to this Health questionnaire to remain confidential?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO

Further details if the response to one of the question is YES (other than question 3)

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

Details

THE INSURER'S 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 Welcome Cover policy.

In date

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

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

Your Insurance Advisor + APRIL Mobilité Code

I

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.



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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

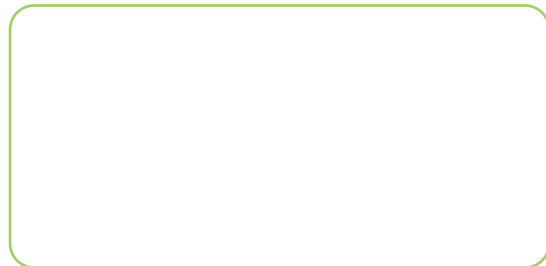
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From our beginnings in 1988, the APRIL GROUP has been committed to changing the face of the insurance industry by ensuring that the client is always at the heart of our business.

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

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