APPLICATION FORM
2017-2018

EXPAT STUDENT

april international

Insurance made easy.

EXPAT STUDENT APPLICATION FORM

Insurance consultant reference number: I56017

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

PLEASE WRITE IN CAPITAL LETTERS

INSURED Person(s) to be insured

If the insured has more than 2 dependent children, please photocopy page 2 and fill it out.

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

Surname of **principal insured:**

First names of **principal insured:**

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

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:

E-mail :

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

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Title of **spouse:** Mrs ◯ Mr ◯

Surname of **spouse:**

First names of **spouse:**

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

Country of nationality:

Country of primary residence abroad:

Status of spouse: Pupil ◯ Student ◯ Au-pair ◯

Degree course/programme: Estimated length of study: years

School or institution of attendance of the spouse:

Is your spouse, or any of their family members, a Politically Exposed Person*? YES ◯ NO ◯

Surname of **1st dependent child:**

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

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

Surname of **2nd dependent child:**

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

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

* *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.*

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:

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State/Region/Land/County:

Country:

Telephone: +

Cell phone: +

Any correspondence from us (your insurance certificate, General conditions, reimbursement statements etc.) will be sent by e-mail.
Your insurance card will be sent by post.

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

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:

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Postcode: City:

State/Region/Land/County:

Country:

Telephone: +

Cell phone: +

E-mail:

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

REIMBURESEMENT METHOD FOR MEDICAL EXPENSES

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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 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

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, 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):

.....

.....

5 **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, 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 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.

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

6 Maximum effective date: 16 September 2018
(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	◯			

► Calculating the annual premium

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Annual premium, principal insured: € ☐☐☐☐,☐☐ A

Annual premium, spouse: € ☐☐☐☐,☐☐ B

Annual premium, children: € ☐☐☐☐,☐☐ C

Annual instalment fees (including membership fee of the Association des Assurés d'APRIL International: €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 30/09/2018. When calculating your premium, remember to take into account the payment frequency selected.

► Paying the first premium:

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

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

Please provide your card details using the box on page 11

Paperless premium notices are available by e-mail or in your online Customer zone.

SIGNATURE OF THE APPLICATION

I hereby apply for membership of the Association des Assurés d'APRIL International under their agreements with Axéria Prévoyance for medical expenses benefit (plan no. A3MCSLDFDS1E2013) and for repatriation assistance, Exam insurance benefit insured by CHUBB (plan no. FRBOTA11959) for the insured listed on the Application form. have read the Association's statutes and regulations (available to download at http://en.aprilinternational.com/global/april-international-expat/association-of-april-international-insured).
I am applying for insurance with Solucia PJ under this policy for legal assistance (contract no. 10006609) and CHUBB for Personal liability private capacity, internships and tenant's liability (contract no. FRBOTA13138).
I have read the General conditions ExS 2017 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 Expat's handling of my insurance cover. 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.

Data Protection and Freedom of Information Law.
Under the French law of 6 January 1978, as amended, I acknowledge that APRIL International Expat, in its capacity as data controller, has informed me that:
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 International Expat, the insurers or their agents for the requirements of my insurance cover.
APRIL International Expat may contact me by telephone regarding my application for insurance unless I opt out by sending an email to: adhesion.expat@april-international.com or by post to the above address.
In application of Article L121-34 of the French Consumer Code, I have the right to opt out of marketing calls and can exercise this right by contacting Opposetel at: http: //www.bloctel.gouv.com
Under the French Act of 6th January 1978 (amended), I have the right to access and, if necessary, rectify any personal information held on file by writing to APRIL International Expat, 110 avenue de la République, CS 51108, 75127 Paris Cedex 11, FRANCE. APRIL International Expat has the right to utilise certain administrative information and to share it with APRIL subsidiaries.
Under the French Act of 6th January 1978 (amended), I have the right to prevent my details being passed on in this way by writing to APRIL InternationalExpat at the above address. Postal charges will be refunded.

I am also entitled to issue instructions relating to the preservation, deletion and passing on of the information held on me, following my death.

If no instructions have been issued, my rights will be extinguished at the time of my death, but my heirs will still be able to: access personal data files processed in connection with me, for the purpose of identifying and securing the release of any information that will assist with settling and distributing my estate, as well as obtaining digital assets or data akin to family mementos, which can be passed on to my heirs; ensure that my death is formally acted upon and, in this connection, to arrange for my user accounts to be closed, and to block any ongoing processing of personal data held on me or to have this updated. I can exercise this right by sending a letter, accompanied by copies of the front and back of an ID document, to the abovementioned address,

Furthermore, in order to meet its legal obligations, APRIL International Expat is implementing a monitoring procedure the purpose of which is to combat money laundering and the financing of terrorism, and the application of financial penalties.

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In accordance with article L561- 45 of the French Monetary and Financial Code, I can exercise my right of access by applying to the French Data Protection Agency, Commission Nationale Informatique et Libertés - 8 rue Vivienne - CS 30223 - 75083 Paris Cedex 02 - FRANCE. However, if the request is in connection with the procedure introduced for the purpose of identifying persons whose assets have been frozen or on whom a financial penalty has been imposed under the French Data

Protection Act 78 -17 of 6th January 1978, I can exercise my right of access by sending a letter, together with a copy of my ID, to APRIL International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Data preservation - My data will be preserved for the periods of time applicable, as set out in the statute of limitations.

I understand that telephone calls to APRIL International Expat may be recorded for administrative purposes and that I may have access to recordings made of my calls by writing to APRIL International Expat 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 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 Expat 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 agree to pay back to APRIL International Expat 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.

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

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

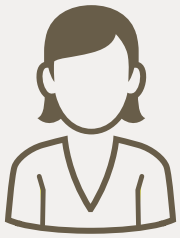
Signature(s) of the principal insured and insured spouse preceded by the words **"I have read, understood and accepted the policy document":**

Signature of the member (if different from the principal insured) preceded by the words **"I have read, understood and accepted the policy document":**

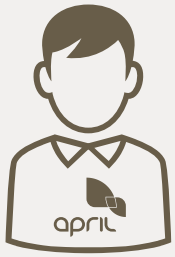
Signature of legal guardian for the minor insurants

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

YOUR APPLICATION STEP BY STEP:



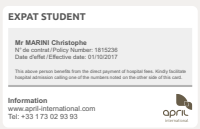
Fill in your Application form and send it to APRIL International Expat.
If you need help, read the tips on the last page or contact us.

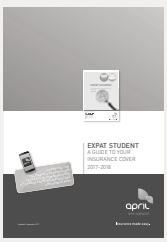


Your application is processed on receipt.

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.**





HEALTH QUESTIONNAIRE

This Health questionnaire is valid for 6 months.

For example, if you want your policy to start on 01/07/2018, you can sign the questionnaire between 01/01/2018 and 30/06/2018.

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 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 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 Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Some of the medical information you provide may be processed electronically for the use of the APRIL International Expat's Medical Examiner. Under the French Act of 6th January 1978 (amended), you have the right to access and, if necessary, rectify any personal information held on file by writing to the APRIL International Expat's Medical Examiner at the above address.

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

DATE OF BIRTH: |_|_|_|_|_|_|_|_| HEIGHT: |_|_|_| cm WEIGHT: |_|_|_| kg

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	Illness(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: ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋ Result: ◯ positive ◯ negative
	b) **HCV** (hepatitis C)?	◯ YES ◯ NO	Date: ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋ Result: ◯ positive ◯ negative
	c) **HIV** (AIDS)?	◯ YES ◯ NO	Date: ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋ Result: ◯ 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 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	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.

9 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 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 father, mother or legal guardian for insured children under 18:

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 Expat 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 Expat.

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 Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - 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 Expat in order to manage your direct debit payments and will be sent only to your bank for this purpose. Under the French Data Protection and Freedom of Information Act of 6th January 1978, amended in 2004, you have the right to access and query your personal information and have this information corrected or deleted. You can exercise this right by writing to the Customer Service department at APRIL International Expat.

Please return this form to APRIL International Expat 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 Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - 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: **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 Expat: 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 Expat, *OR*
- provide your credit/debit card details on page 11 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 Expat - Service Adhésions Individuelles
110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - 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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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
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 - 61, rue Taitbout - 75436 Paris Cedex 09 - FRANCE
NAF6622Z - Intra-community VAT N° FR603009707727
Product insured by Axéria Prévoyance (health care warranties plans n°A3MCSLDFDS1E2013 and A3MCSLDFDSRO2013),
Limited Company of insurance with capital of 31 000 000 €, company regulated by the French Insurance Code.
Headquarters: 90 avenue Félix Faure, 69439 Lyon Cedex 03, FRANCE, registered with RCS de Lyon under number 350 261 129.

april international

Insurance made easy.