



**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:  /  /

Nationality:

Country of residence abroad:

Occupation:

**3** Surname of **1<sup>st</sup> dependent child**:

First names of **1<sup>st</sup> dependent child**:

Date of birth:  /  /  Sex:  Male  Female

**4** Surname of **2<sup>nd</sup> dependent child**:

First names of **2<sup>nd</sup> dependent child**:

Date of birth:  /  /  Sex:  Male  Female

**5** Surname of **3<sup>rd</sup> dependent child**:

First names of **3<sup>rd</sup> dependent child**:

Date of birth:  /  /  Sex:  Male  Female

**If the insured have more than 3 dependent children, please photocopy page 2 and fill it out.**

**INSURED Address abroad**

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*



→ **Mailing address of the person paying the premium, for delivery of premium reminder notices**  
(if different from the main address)

Individual

Corporate

Name of company:

Title: Mrs  Miss  Mr

Surname:

First names:

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

Street name:

Street name (continued):

Postcode:

Town or City:

State/Region/Canton/Land/Country:

Country:

Telephone:  /  /  /  /  /  *If outside France*

E-mail:

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

You can update your details at [www.aprilmobilite.com](http://www.aprilmobilite.com).

**CHOICE OF BENEFITS AND LEVEL OF COVER:**

**1 Repatriation assistance**

Individual membership  Family membership

European and Mediterranean countries  Worldwide

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.  
In the case of an individual application made by each member of the same family, the same option must be selected for the entire family.*

Country of residence in zone A  Country of residence in zone B  Country of residence in zone C

PRIMO option  INTERMEDIO option  EXTENSO option

Annual premium (all taxes included): €  **B**

Method selected for payment of medical expenses reimbursements:

Cheque  Bank transfer (**send bank details with your application**)





## **Signature of the Member**

*I hereby apply for membership of the Association of APRIL Insured under their agreements with Gan Eurocourtage Vie, Gan Eurocourtage IARD and Inter Partner Assistance for myself and the beneficiaries listed on the Application form.*

*I have read the Association's statutes and regulations.*

*I have read the General conditions and booklet Am 2008 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 6<sup>th</sup> 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, 75011 Paris, 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 6<sup>th</sup> 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 may at any time, and in writing, stop copies of my statutory Healthcare reimbursements being sent from Social Security to APRIL Mobilité.*

*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 Association of APRIL Insured.*

*I agree to pay APRIL Mobilité any reimbursements made to me by Social Security or any private healthcare insurer, if option 1 selected.*

In ..... Date .....

**Signature(s) of the insured, the policyholder and insured spouse or common-law spouse preceded by the words « I have read, understood and accepted the policy document »:**

# Health questionnaire

**To be completed not more than 6 months before the commencement of cover**

If you are leaving on 01/07/2008, you can sign this declaration between 01/01/2008 and 30/06/2008

**Please read the Health questionnaire carefully. The questionnaire is an important part of the insurance contract and must be dated and signed. You must answer all the questions.**

<b>1</b>	Height	
<b>2</b>	Weight	
<b>3</b>	Are you currently on partial or total sick leave from work due to illness or accident?	
<b>4</b>	Within the <b>last 10 years</b> , have you: a) undergone surgery? b) undergone laser treatment, chemotherapy or radiation therapy?	
<b>5</b>	Within the <b>last 5 years</b> , 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?	
<b>6</b>	Within the <b>last 5 years</b> , 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...)?	
<b>7</b>	Do you suffer from any disorder or illness requiring regular medical supervision or treatment?	
<b>8</b>	Have you been tested for HBV (Hepatitis B)? If you answered "Yes" to this question, were the results positive?	<i>Date of the test:</i>
<b>8 Bis</b>	Have you been tested for HCV (Hepatitis C)? If you answered "Yes" to this question, were the results positive?	<i>Date of the test:</i>
<b>8 Ter</b>	Have you been tested for HIV (AIDS)? If you answered "Yes" to this question, were the results positive?	<i>Date of the test:</i>
<b>9</b>	Do you have a disability which entitles you to benefits?	
<b>10</b>	Will you undergo any diagnostic test <b>over the next 6 months</b> (lab tests, scans, endoscopy...) and /or have a consultation with a specialist and/or any treatment or surgery?	
<b>11</b>	Within the <b>last 12 months</b> , 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...?	
<b>12</b>	Do you have, or have you ever had 100% cover from Social Security or the Caisse des Français de l'Étranger for a long-term complaint (with no contribution you towards costs)?	
<b>13</b>	Do you want your responses to this Health questionnaire to remain confidential?	

**Any medical information you provide is held in strict confidence in accordance with the Belorgey and AREAS conventions. Detailed answers will help us process your application promptly.**

**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.**

	Policyholder	Spouse or Common-law spouse	1 <sup>st</sup> dependent child	2 <sup>nd</sup> dependent child	3 <sup>rd</sup> dependent child
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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 Applications Medical Department to the following address: APRIL Mobilité – 110, avenue de la République – 75011 Paris – FRANCE.

#### Additional Information:

If you answered **YES** to any of the questions (other than question 13), 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 Association of APRIL Insured.

In ..... Date .....

**Signature(s) of person to be insured, spouse, common-law spouse and insured children preceded by the words « I have read, understood and accepted the policy document » :**

#### Your Insurance Advisor + APRIL Mobilité Code:

ONE CARE INTERNATIONAL  
24 RUE DE LA TOUR D'AUVERGNE  
75009 PARIS  
Téléphone : 01 49 70 66 58  
E-mail : [contact@expat-courtage.com](mailto:contact@expat-courtage.com)  
[www.expat-courtage.com](http://www.expat-courtage.com)  
code I 53779

# 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 - 75011 Paris - 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:

**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](http://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](http://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 **2 million people** know they can count on our **2060 employees** and 42 companies to protect their goods and families day after day.

**For more information,** contact your insurance consultant:

ONE CARE INTERNATIONAL  
24 RUE DE LA TOUR D'AUVERGNE  
75009 PARIS  
Téléphone : 01 49 70 66 58  
E-mail : [contact@expat-courtage.com](mailto:contact@expat-courtage.com)  
[www.expat-courtage.com](http://www.expat-courtage.com)  
code I 53779

**APRIL MOBILITÉ MEMBER OF APRIL GROUP**

### Headquarters

110, avenue de la République - 75011 Paris - FRANCE

Tel: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90

E-mail: [info@aprilmobilite.com](mailto:info@aprilmobilite.com) - Internet: [www.aprilmobilite.com](http://www.aprilmobilite.com)

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Regulatory body for Insurance Activities - 61, rue Taitbout 75436 Paris cedex 09

