My Health International

Application Form 2021-2022

April International
INSURANCE MADE EASY

STAATENLOS
WEIL DEIN LEBEN DIR GEHÖRT
Staatenlos Rahmenvertrag

Updated: September 2021

We are delighted you want to become a member.

These are the steps to follow to apply for membership of the plan:

1

Complete your Application form and send it to APRIL International Care France.

If you need help, read the tips on the last page or contact us.

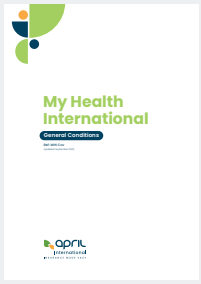
2

We process your application as soon as it arrives.

3

You will be sent:

- your General conditions describing how your plan operates,
- your insurance card showing the emergency numbers to use if you need assistance or before going into hospital,
- your Members' guide with a summary of how your plan operates and all the contact details you will need.



APPLYING FOR MEMBERSHIP

A. Check all information in this document.

B. Date and sign your Application form in section 9.

C. Date, complete and sign the Health questionnaire(s).

D.
- To pay your first premium, you can:
  - enclose a cheque made payable to APRIL International Care France, ***OR***
  - enter your card details on page 12 of the Application form, ***OR***
  - arrange a bank transfer (in this case, please enclose a copy of the transfer order).
- For future premiums, complete the SEPA direct debit mandate if you want to pay your instalments by direct debit from a bank account in euros (the account must be located within the SEPA zone).

E. Enclose a current Social Security certificate for each person applying for French Social Security top-up cover.

F. If you want to request the non-application of the waiting periods for medical expenses cover, enclose the Exit certificate of less than a month from your previous plan together with details of the cover you had under this plan.

G. If you have taken out additional cover, please also send us the following supporting documents:
- the death and loss of autonomy lump sum: **a copy of your identity document (national identity card or passport)**,
- for income protection benefit, if you have selected an amount greater than €/$ 80: a copy of your latest tax notice and your most recent payslip.

SEND THESE DOCUMENTS:

by email to: adhesiontacite.expat@april-international.com

OR

by post to: APRIL International Care France - Service Courrier
1 rue du Mont - CS 80010 - 81700 Blan - FRANCE

OUR MULTILINGUAL TEAMS ARE AVAILABLE TO ASSIST:

By telephone:
+33 (0)1 73 02 93 93
Monday to Friday
from 8.30am to 6pm
Paris time

By email:
info.expat@april-international.com

At our offices:
14 rue Gerty Archimède
75012 PARIS
FRANCE

Insurance consultant reference number: I

APPLICATION FORM My HEALTH INTERNATIONAL

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

PLEASE WRITE IN CAPITAL LETTERS

File reference:

INSURED Person(s) to be insured

Title of **principal insured**: Ms ◯ Mr ◯ Date of birth: / /

Surname of **principal insured**:

First names of **principal insured**:

Country of nationality:

Occupation:

Business sector:

Social Security number/CFE number: Check digit:
(if you are applying for Social Security/CFE top-up insurance)

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

Email:

▶ INFORMATION ABOUT YOUR CURRENT INTERNATIONAL HEALTH COVER

1

◯ **None**

◯ **Local healthcare scheme**

◯ **Private insurance**
- Name of your Insurer:
- Start date of your current plan (MM/YYYY): /
- End date of your current plan (MM/YYYY): /

Title of **spouse**: Ms ◯ Mr ◯ Date of birth: / /

Surname of **spouse**:

First names of **spouse**:

Country of nationality:

Occupation:

Business sector:

Social Security number/CFE number: Check digit:
(if you are applying for Social Security/CFE top-up insurance)

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

Email:

Surname of **1st dependent child**:

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

Date of birth: / / Sex: Male ◯ Female ◯

Social Security number/CFE number: Check digit:
(if you are applying for Social Security/CFE top-up insurance)

**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.*

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

Surname of **2nd dependent child**:

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

Date of birth: / / Sex: Male ◯ Female ◯

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **3rd dependent child**:

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

Date of birth: / / Sex: Male ◯ Female ◯

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **4th dependent child**:

First names of **4th dependent child**:

Date of birth: / / Sex: Male ◯ Female ◯

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

1

Surname of **5th dependent child**:

First names of **5th dependent child**:

Date of birth: / / Sex: Male ◯ Female ◯

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **6th dependent child**:

First names of **6th dependent child**:

Date of birth: / / Sex: Male ◯ Female ◯

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

Surname of **7th dependent child**:

First names of **7th dependent child**:

Date of birth: / / Sex: Male ◯ Female ◯

Social Security number/CFE number: Check digit:

(if you are applying for Social Security/CFE top-up insurance)

PRINCIPAL INSURED — Address for delivery of correspondence

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Address:

Postcode:

Town/city:

State/Region/Land/County:

Country:

Landline: Mobile:

MEMBER : WHO IS PAYING THE PREMIUM

- ◯ **The principal insured is paying the premium** (in this case, the details below are not required)
- ◯ **The person paying the premium is not the principal insured**

Individual ◯ **Company** ◯ **Company name:**

Title: Ms ◯ Mr ◯

Surname:

First names:

3

Address:

Postcode:

Town/city:

State/Region/Land/County:

Country:

Landline: Mobile:

Email:

REIMBURSEMENT METHOD FOR MEDICAL EXPENSES:

- ◯ transfer to a bank account in France
- ◯ transfer to a bank account in the United States
- ◯ transfer to a bank account in another country

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Depending on the location of your bank account, charges may be applied by your bank. The reimbursement will be processed in the currency in which your plan is managed, € or US$ (see article 5 of the General Conditions, PREMIUMS).

Account holder:

Account number:

BIC/SWIFT Code:

YOUR COVER:

▸ **CURRENCY:** ◯ € ou ◯ US$

▸ **TYPE OF COVER:** ◯ Cover from the 1st €/US$

◯ Cover as a top-up to the Caisse des Français de l'Étranger (CFE)

◯ Cover as a top-up to French Social Security

▸ **LEVEL OF HEALTHCARE COVER:**

HEALTHCARE BENEFIT	EMERGENCY	BASIC*	ESSENTIAL	COMFORT	PREMIUM
Hospitalisation only	◯	◯	◯	◯	◯
Hospitalisation + Outpatient benefits	—	◯	◯	◯	◯
Hospitalisation + Outpatient benefits + Optical-Dental care	—	◯	◯	◯	◯
Hospitalisation + Outpatient benefits + Maternity	—	—	◯	◯	◯
Hospitalisation + Outpatient benefits + Maternity + Optical-Dental care	—	—	◯	◯	◯

* Not available if you choose cover in the United States, the Bahamas, Puerto Rico or Worldwide cover.

▸ **COVERED COUNTRIES:**

Destination country:

Extend cover: ◯ Worldwide ◯ No extension

◯ Other countries:

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▸ **DEDUCTIBLE AND LEVEL OF REIMBURSEMENT:**

DEDUCTIBLE	No deductible	€/$500	€/$1.000	€/$2.500	€/$5.000
	◯	◯	◯	◯	◯

OR

LEVEL OF REIMBURSEMENT	100% of actual costs	90% of actual costs	80% of actual costs
	◯	◯	◯

▸ **Annual premium:** ,

◯ COMPREHENSIVE REPATRIATION ASSISTANCE AND PERSONAL LIABILITY (PRIVATE CAPACITY)

▸ **Annual premium:** ,

◯ DEATH AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY LUMP SUM

Amount of cover requested for the principal insured (between €/$20,000 and €/$500,000): ,

Amount of cover requested for the spouse (between €/$20,000 and €/$500,000): ,

▸ **Annual premium:** ,

DESIGNATION OF BENEFICIARIES OF THE DEATH AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY LUMP SUM

Depending on the amount of death benefit selected, certain **medical formalities** are required. Please refer to page 8 of the benefits schedule. The designated beneficiaries must be **private individuals**.

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

◯ My surviving spouse provided we are not legally separated when the lump sum becomes payable, failing which my living, unborn or represented children in equal parts, failing which my ascendants in equal parts, failing which my heirs.

◯ Other beneficiaries (please specify their **surname, first name, date and place of birth and percentage of the lump sum to be allocated**):

.....

.....

.....

Spouse: I designate as beneficiary (or beneficiaries) in the event of my death:

◯ My surviving spouse provided we are not legally separated when the lump sum becomes payable, failing which my living, unborn or represented children in equal parts, failing which my ascendants in equal parts, failing which my heirs.

◯ Other beneficiaries (please specify their **surname, first name, date and place of birth and percentage of the lump sum to be allocated**):

.....

.....

.....

If no specific beneficiary has been designated, the death lump sum will be paid to the surviving spouse provided you are not legally separated when the lump sum becomes payable; failing which to the living, unborn or represented children in equal parts, failing which to the ascendants in equal parts, failing which to the heirs.

ADDITIONAL INFORMATION IF YOU ARE APPLYING FOR INCOME PROTECTION COVER

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The medical formalities required are based on the level of the death lump sum selected.

Principal insured

Net annual salary[1,2]: ☐☐☐☐☐☐ € ◯ $ ◯

Daily benefit from the CFE/French Social Security: € ☐☐☐
(if you are applying for Social Security/CFE top-up insurance)[3]

Amount of daily benefit requested: ☐☐☐

Is the principal insured in a business start-up situation? ◯ YES ◯ NO

Deferred period: ◯ 30 days ◯ 60 days

Spouse

Net annual salary[1,2]: ☐☐☐☐☐☐ € ◯ $ ◯

Daily benefit from the CFE/French Social Security: € ☐☐☐
(if you are applying for Social Security/CFE top-up insurance)[3]

Amount of daily benefit requested: ☐☐☐

Is the spouse in a business start-up situation? ◯ YES ◯ NO

Deferred period: ◯ 30 days ◯ 60 days

If you or your spouse want to purchase a daily benefit greater than €/$80, please enclose a copy of your latest tax notice and your most recent payslip.

▸ **Annual premium:** ☐☐☐☐☐, ☐☐

[1] *Champs obligatoires*
[2] *Si vous êtes en création ou en reprise d'activité, l'équivalent mensuel de l'indemnité journalière ne pourra pas dépasser 70% de votre ancien revenu net mensuel.*
[3] *Dans ce cas le total mensuel des indemnités journalières perçu par le régime de base et au titre du contrat Ma Santé Internationale ne peut pas être supérieur à 100% du salaire net mensuel.*

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Effective date: ☐☐ / ☐☐ / ☐☐☐☐

(Subject to your application being approved and at the earliest on the day following receipt of the Application form. If your application requires a medical review, your plan will start at the earliest on the day of signature of acceptance of the proposed conditions.)

Calculating and paying the premium

CHOOSE HOW YOU WANT TO PAY YOUR PREMIUM:	Choose your preferred payment method by ticking one of the following options:				
	SEPA direct debit from a bank account in Euros	Bank card €/$	PayPal €/$	Bank transfer €/$	Cheque €/$
Annually	◯	◯	◯	◯	◯
Twice-yearly	◯	◯ €/$20 per half-year, or €/$40 per year	◯ €/$20 per half-year, or €/$40 per year	◯ €/$20 per half-year, or €/$40 per year	◯ €/$20 per half-year, or €/$40 per year
Quarterly instalments	◯	◯ €/$20 per quarter, or €/$80 per year	◯ €/$20 per quarter, or €/$80 per year	◯ €/$20 per quarter, or €/$80 per year	◯ €/$20 per quarter, or €/$80 per year
Monthly instalments	◯	—	—	—	—

▸ CALCULATING THE ANNUAL PREMIUM

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tal annual premium all taxes included (as per the pricing proposal received): ☐☐☐☐☐,☐☐

Annual fee for membership of the Association des Assurés APRIL in addition to the selected benefits: + ☐☐,☐☐

Annual instalment charges (unless you are paying by SEPA direct debit or making a single annual payment): + ☐☐,☐☐

Total* annual premium: ☐☐☐☐☐,☐☐

*Premiums may be readjusted on the anniversary date of your plan based on the claims history of the insured group.

Total amount of 1st premium: ☐☐☐☐☐,☐☐
Your 1st payment is the 1st instalment of the total annual premium.

Pay the 1st premium:

◯ by cheque made payable to **APRIL International Care France** or by bank transfer.

◯ by bank card (Eurocard-Mastercard, VISA and American Express).
Please enter your card details in the box on page 12.

◯ with PayPal (only in case of an online subscription).

Pay future premiums:

◯ by cheque, bank transfer, bank card or PayPal. For these four payment methods, it is your responsibility to pay the instalments when they are due.

◯ by SEPA direct debit. Please send us your bank details and complete the SEPA direct debit mandate below.

Paperless premium notices can be sent by email or accessed in your online Customer zone.

SIGNING THE APPLICATION

I hereby apply for membership of the Association des Assurés APRIL under their agreements with Groupama Gan Vie for medical expenses, death and total and irreversible loss of autonomy and income protection cover and CHUBB for repatriation assistance and personal liability (private capacity) cover for the insured members listed on the Application form. I have read the statutes of the Association des Assurés APRIL (available in the General conditions).

I have read the Insurance Product Information Document MHICov22IPID and the General conditions (serving as the information notice, reference MHI Cov) and 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 Care handling of my insurance cover. My membership is renewed automatically on the plan's anniversary date for a period of one year.

If my plan is amended by means of an endorsement, I accept that the General conditions applied will be those referred to above.

I understand that APRIL International Care is required to collect my personal data. Information on how the data is processed and how I can exercise my rights in respect of this data can be found in the APRIL International Care France "Information notice - the processing of your personal data (RGPD)" provided to me.

I understand that cover under this plan does not exempt me from paying contributions to any state benefits 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 Care France requires me to declare any similar insurance cover which I may have purchased from other insurers and that certain benefits are subject to waiting periods.

I understand that the insurers will not cover any costs deemed to be unreasonable and unusual considering the location in which they were incurred.

If I have taken out insurance as a top-up to the CFE/French Social Security, my Social Security centre will be sent a certain amount of information. I may opt out in writing and at any time of the forwarding by Social Security of copies of my Social Security statements to APRIL International Care France.

If I have taken out insurance cover from the 1st euro/dollar, I agree to return to APRIL International Care France any amounts paid to me by any Social Security body and/or any other healthcare or death & disability insurance provider.

I understand that the pre-contractual and contractual relations in respect of this policy are governed by French law and the French language.

9 **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 would like to receive offers from APRIL's partners by email.

Signed in (town or city) _____ on (DDMMYYYY) ☐☐/☐☐/☐☐☐☐

(We cannot accept applications signed in the United States.)

Signature of the principal insured preceded by the words **"Read and approved"**:	Signature of the spouse preceded by the words **"Read and approved"**:	Signature of the payer of the premium (if different from the principal insured) preceded by the words **"Read and approved"**:

To insure children under the age of 18, the payer of the premium must sign the Application form and must be the parent, legal guardian or person exercising parental authority.

CANCELLATION

ARTICLE L.112-9 AND L132-5-1 OF THE FRENCH INSURANCE CODE

If you decide to waive your insurance, you can use the tear-off slip below and send it to:
APRIL International Care France - Service Courrier - 1 rue du Mont - CS80010 - 81700 Blan - FRANCE

Article L.112-9: "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 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."

Article L.132-5-1: "Any individual who has signed a life insurance or endowment proposal or contract has the option of cancelling it by registered letter or registered email with requested proof of delivery within 30 calendar days from the time they are informed that the contract has been concluded. This cancellation period expires at midnight on the last day. If it expires on a Saturday, Sunday or a public holiday or non-business day, it is not extended.
The cancellation triggers the refund by the insurance or endowment company of all the sums paid by the contracting party within a maximum period of thirty calendar days following receipt of the registered letter or registered email. Beyond this period, any sums which have not been refunded automatically generate interest at the legal rate increased by one half for two months and then, on expiry of this two-month period, at twice the legal rate."

Conditions: If you wish to cancel your insurance policy, please fi ll 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 (or 30 days for a life insurance) 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: **MyHealth International Ref. MHI Cov**

Date of signature of Application form: / /

Member's surname:

Member's fi rst name:

Member's address:

Postcode: Town/city:

Country:

Telephone: / / / / / /

Name of insurance consultant:

Address of insurance consultant:

Postcode: Town/city:

Country:

Telephone: / / / / / /

Date (DDMMYYYY): / /

Member's signature:

Reserved for APRIL International Care France: 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 ◯ American Express

Card number: ____ / ____ / ____ / ____ Expiry date (MM/YY): __ / __

Card security code: ___ (the 3 digit number printed on the backside of your Mastercard and VISA branded card or a 4 digit number on the front side of your American Express card).

Card owner: ____________________________________

APRIL International Care France Head Office:

14 rue Gerty Archimède - 75012 Paris - 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
4 place de Budapest - CS 92459 - 75436 PARIS CEDEX 09 - FRANCE.
This product is conceived and managed by APRIL International Care France and insured by Groupama Gan Vie (for the medical expenses cover, the death and total and irreversible loss of autonomy cover and the income protection cover) and Chubb European Group SE (for the repatriation assistance cover and the personal liability private capacity cover).
NAF6622Z - Intra-community VAT N° FR603009707727

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INSURANCE MADE EASY