MyHealth France

Application form

april International

INSURANCE MADE EASY

MyHealth France APPLICATION FORM

Insurance consultant reference number: I

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**: Mrs ◯ Mr ◯ Date of birth: / /

Surname of **principal insured**:

Birth name of **principal insured**:

First names of **principal insured**:

Country of birth:

Country of nationality:

Host country: FRANCE

Home address:

Postcode: City:

Region:

Occupation:

Professional category:

Email:

Social Security number: Check digit:

1 Statutory scheme centre number: (9-digit number, available on your Social Security certificate)

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

Surname of **spouse**:

Birth name of **spouse**:

First names of **spouse**:

Country of birth:

Country of nationality:

Host country: FRANCE

Occupation:

Professional category:

Email:

Social Security number: Check digit:

Statutory scheme centre number: (9-digit number, available on your Social Security certificate)

Surname of 1st **dependent child**:

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

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

Social Security number: Check digit:

Statutory scheme centre number: (9-digit number, available on your Social Security certificate)

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

Surname of **2nd dependant child**:

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

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

Social Security number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

Statutory scheme centre number: ☐☐☐☐☐☐☐☐☐ (9-digit number, available on your Social Security certificate)

Surname of **3rd dependant child**:

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

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

Social Security number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

Statutory scheme centre number: ☐☐☐☐☐☐☐☐☐ (9-digit number, available on your Social Security certificate)

Surname of **4th dependant child**:

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

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

Social Security number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

Statutory scheme centre number: ☐☐☐☐☐☐☐☐☐ (9-digit number, available on your Social Security certificate)

1

Surname of **5th dependant child**:

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

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

Social Security number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

Statutory scheme centre number: ☐☐☐☐☐☐☐☐☐ (9-digit number, available on your Social Security certificate)

Surname of **6th dependant child**:

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

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

Social Security number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

Statutory scheme centre number: ☐☐☐☐☐☐☐☐☐ (9-digit number, available on your Social Security certificate)

Surname of **7th dependant child**:

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

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

Social Security number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

Statutory scheme centre number: ☐☐☐☐☐☐☐☐☐ (9-digit number, available on your Social Security certificate)

PRINCIPAL INSURED — Address for delivery of correspondence

2

Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: + / Mobile: +

Any correspondence from us (your insurance certificate, general conditions, reimbursement statements etc.) will be sent by email. Your direct billing card will be sent by post.

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

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 ◯ **Corporate** ◯

Title: Mrs ◯ Mr ◯

3

Surname:

First names:

Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: + / Mobile: +

Email:

(this email will allow you to have access to your Member Portal)

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

Additional information if the person paying the premium is a Company

Name of company:

Name of the Beneficial Owner of the company:

Birth name of the Beneficial Owner of the company:

First names of the Beneficial Owner of the company:

Date of birth of the Beneficial Owner of the company: / /

Please attach a copy of the Document relating to the Beneficial owner(s) of the company.

TERMINATION OF THE PREVIOUS INSURANCE PLAN

(TERMINATION OF PLANS MORE THAN 12 MONTHS OLD - ARTICLE L113-15-2 OF THE FRENCH INSURANCE CODE)

Are you about to terminate a policy which has been in place with another insurer for more than 12 months? YES ◯ NO ◯

If **YES**, and if you would like APRIL International Care France to deal with the termination of your existing supplementary health insurance plan, please provide us with the contact details of the current insurance company.

4

Name of the insurance company:

Address:

Postcode: City:

Plan reference number:

Name of the plan member:

CHOICE OF BENEFITS AND LEVELS OF COVER

Medical expenses cover as a top-up to the French Social Security (or equivalent French scheme)

Individual membership

5 Option: ◯ LEVEL 1 ◯ LEVEL 2 ◯ LEVEL 3 ◯ LEVEL 4 ◯ LEVEL 5 ◯ LEVEL 6

Please send us a photocopy of your current Social Security certificate for your policy to take effect

i **The reimbursements are made by transfer to a bank account in France. In this case, please send us details of your bank account.**

6 Choice of effective start date: ☐☐ / ☐☐ / ☐☐☐☐

(subject to your application being approved and at the earliest on the day following receipt of the Application form)

7 Calculating and paying the premium

SELECT THE PAYMENT FREQUENCY:	Tick your chosen payment method:	
	SEPA direct debit from a bank account in Euros	Bank card
Annually	◯	◯
Monthly	◯	Unavailable

► CALCULATING THE ANNUAL PREMIUM

Principal insured's annual premium: € ☐☐☐☐☐,☐☐ A

Spouse's annual premium: € ☐☐☐☐☐,☐☐ B

Dependent child(ren) annual premium: € ☐☐☐☐☐,☐☐ C

Annual membership fee of the Association des Assurés APRIL in addition to selected benefits: + € 3,00 D

Total premiums* for 12 months: A + B + C + D: € ☐☐☐☐☐,☐☐ E

*Premiums may be readjusted on 1st January each year depending on the claims history of the insured group.

► CALCULATING THE MONTHLY PREMIUM

Total premiums for 12 months*: € ☐☐☐☐☐,☐☐ E

*Premiums may be readjusted on 1st January each year depending on the claims history of the insured group.

Amount of monthly premium (if monthly payments have been selected)**: E ÷ 12 :** € ☐☐☐☐☐,☐☐ F

Total amount of first premium: € ☐☐☐☐☐,☐☐

The first premium is a pro rata amount of the annual premium which is valid from the effective start date of your policy until 31/12. When calculating your premium, remember to take into account the selected payment frequency.

Good news! You can pay by SEPA direct debit from the first premium!
The payment method you choose will apply to all your payments.

Example : if you have chosen payment by SEPA direct debit, your first premium and the following ones will be withdrawn automatically on the communicated bank account.

Deductibility "Loi Madelin": ◯ YES ◯ NO

If you are a non-agricultural self-employed person and you have subscribed to a responsible plan, you can benefit from the deductibility of your contributions under law n°94-0126 of 11/02/1994. Before proceeding to the deduction of your contributions from your professional income, you must ensure that you meet the other conditions laid down by the Code Général des Impôts.

SIGNING THE APPLICATION

I hereby apply for membership of the Association des assurés APRIL and the agreements it has entered into with QUATREM (3AMHFFDSNR2018 and 3AMHFFDSR2018) for myself and my dependants listed on the application form. QUATREM is an insurance company governed by the French Insurance Code, a French public limited company with a capital of €510,426,261, whose head office is located at 21 rue Laffitte, 75009 Paris, FRANCE. It is registered with the Paris Trade & Companies register under number 412 367 724.
I confirm that, before entering into the insurance contract, I received and familiarised myself with the Product Information Document MHFCovIPID. The provisions of these agreements describing the benefits and how they apply and the formalities to be completed in the event of a claim are set out in the MyHealth France Information booklet serving as the General Conditions. I confirm that I received a copy of this document when joining the plan, have read it, accept its provisions and have retained a copy. On joining the plan, I received a copy of the benefits schedule, have read it, accepted its provisions and retained a copy.
I also confirm that I have read the extract of the articles of the Association des assurés APRIL which was provided with the Information booklet and can be viewed in full at www.association-assures-april.fr as well as the terms and conditions of APRIL International Care's handling of my insurance cover.
I have been informed that I can cancel my insurance plan by a letter with proof of delivery within the period specified in the Information booklet serving as the general conditions and that my insurance plan is automatically renewable at each annual renewal date, meaning 31st December of each year.
My right to cancel may be exercised using the wording of the template provided on page 9.
If my insurance plans are amended by means of an endorsement, I have noted that the Information booklet serving as the general conditions is the one I read when signing the initial application form referenced above.
The personal data collected by APRIL International Care France is essential for the processing of the application for insurance.
It is governed by (EU) Data Protection Regulation No. 2016/679 of 27th April 2016. By signing the application form, data subjects give their consent to the processing of their personal data.
This data is processed electronically for the purposes of studying, arranging and managing the insurance cover, the implementation of legal and/or regulatory obligations and the improvement of products and services.
APRIL International Care France has also implemented a procedure to combat insurance fraud. This may result in the application of civil, financial and/or criminal sanctions and inclusion on a list of persons presenting a risk of fraud.
To meet its legal obligations, APRIL International Care France has also implemented a monitoring procedure the purpose of which is to combat money laundering and the financing of terrorism, and the application of financial penalties.
This data is intended for the insurer and APRIL International Care France in their capacity as processors of the data.
Depending on the purpose of the processing, it may also be passed on to their partners, subcontractors and the public authorities in accordance with the law.
To help us measure and improve our quality of service, letters, faxes, emails and telephone conversations sent or made to APRIL International Care France may be analysed, recorded and processed electronically for which purpose your personal data may be passed on only to APRIL International Care France, its partners and subcontractors. Personal data is stored for the duration required for the purpose of its processing and in accordance with the statutory time limits.
It may be transferred outside the European Union. These transfers are subject to data protection and security rules. Information about the transferred data and the recipients will be provided by APRIL International Care France on request from the address shown below.
In accordance with (EU) Data Protection Regulation No. 2016/679 of 27th April 2016, data subjects have the right to access their personal information, have it corrected, restricted, deleted and, for legitimate reasons, opt out of this information being processed. They also have the right to portability of their data and the right to set guidelines with respect to what happens to their data after their death, except in cases where the regulations do not allow these rights to be exercised.
As the statutory health insurance scheme receives a certain amount of information, these persons may at any time and in writing opt out of copies of their Statutory Scheme statements being sent to APRIL International Care France France.
To exercise one or more of these rights, a copy of an identity document should be sent to the APRIL Data Protection Officer by post at the following address: APRIL International Care France, Service Courrier, 1 rue du Mont, CS 80010, 81700 Blan, FRANCE or by email to dpo.AICF@april.com.
In accordance with the provisions of Article L561-45 of the French Monetary and Financial Code, persons affected by monitoring of their data may exercise their right of access by applying to the French Data Protection Authority, Commission Nationale Informatique et Libertés - 3 Place de Fontenoy - TSA 80715 - 75334 PARIS CEDEX 07. Complaints relating to the processing of personal data should be made to the French Data Protection Authority, Commission Nationale Informatique et Libertés, on its website www.cnil.fr or by post at the address shown above.
In application of the provisions of Articles L223-1 onwards of the French Consumer Code, you are informed that data subjects may register on the cold-calling opt-out list either by post, by writing to: OPPOSETEL - Service BLOCTEL - 6 rue Nicolas Siret - 10300 TROYES or by visiting the OPPOSETEL website at the following address: bloctel.gouv.fr. This service is free of charge.
Under no circumstances does inclusion on this list prohibit the insurer and APRIL International Care France from contacting them by telephone within the framework of existing contractual relations.
I undertake to inform all persons covered by this membership application of their enrolment in the plan and to pass on to them the information provided to me by APRIL International Care France in respect of the processing of their personal data and the rights to which they are entitled.

I, the undersigned, confirm that I have answered the questions personally, accurately and honestly and have neither included or omitted anything which might mislead the Insurer. I have been informed that any non-disclosure or misrepresentation will result in the application of the sanctions set out under articles L113-8 and L113-9 of the French Insurance Code.

8

☐ I would like to receive offers from APRIL's partners by email.

Signed in (town or city) _____ date ☐☐/☐☐/☐☐☐☐

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 insured) preceded by the words **"I have read, understood and accepted the policy document":**	**Insurance consultant stamp + APRIL International Care Code**
		I☐☐☐☐☐☐☐

PLEASE FIND BELOW INFORMATION ON THE **MEDICAL EXPENSES COVER** PROVIDED UNDER THE HEALTH INSURANCE PLANS INSURED BY QUATREM:

- **The benefit/premium ratio for the medical expenses cover is 76,70%.**

The ratio between the amount of the benefits paid for the reimbursement of and compensation for expenses incurred as a result of illness, maternity or accident and the amount of the contributions or premiums payable in return for these benefits represents the portion of the contributions or premiums, exclusive of tax, collected by the insurer QUATREM in respect of all cover of the reimbursement of or compensation for the above-mentioned expenses, which is used for the payment of the benefits corresponding to this cover.

- **The management fees/premium ratio for the medical expenses cover is 27,40%.**

The ratio between the total amount of the management fees in respect of the reimbursement of and compensation for expenses incurred as a result of illness, maternity or accident and the amount of the contributions or premiums payable in return for these benefits represents the portion of the contributions or premiums, excluding taxes, collected by the insurer QUATREM in respect of all cover of the reimbursement of or compensation for the above-mentioned expenses, which is used to fund the management fees.
These management fees cover all sums incurred in the design of the plans, their commercialisation (including the sales network, marketing and commission paid to intermediaries), their purchase (including collection of the premiums, management of cancellations, tracking of accounts and legal monitoring) and their management (including claims for reimbursement, management of the direct billing service, customer information, assistance, services and additional benefits), i.e. all the tasks for which the insurer is responsible in compliance with the contractual guarantees.

YOUR APPLICATION STEP BY STEP:

Fill in 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.

1

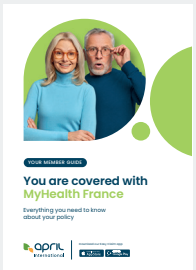
Your application is processed on receipt.

2

You will be sent:

- **your Membership certificate serving as your Insurance Certificate,**
- **a new copy of the General conditions showing how your policy operates,**
- **your direct billing card,**
- **a Guide to your insurance cover, giving an overview of how your policy works and all the useful contact details.**


Membership certificate MyHealth France



SEPA direct debit mandate

(to be completed if selecting payment by direct debit)

Your quote/policy reference:

Unique Mandate Reference (to be completed by the creditor):

By signing this mandate form, you authorise (A) APRIL International Care France 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 Care France.

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:

Name of bank*:

Type of paymen* (tick where appropriate): ☑ Recurring payment ○ One-off payment

CREDITOR:

APRIL International Care France - 14 rue Gerty Archimède - 75012 Paris - FRANCE
SEPA creditor identification number: FR54ZZZ004082

Signed in (town or city)*:

Date (DDMMYYYY)*: / /

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 Care France in order to manage your direct debit payments and will be sent only to your bank for this purpose. In accordance with (EU) Data Protection Regulation No. 2016/679 of 27th April 2016, you have the right to access your personal information, have it corrected, deleted, opt out of this information being processed and restrict its processing and portability. You also have the right to set guidelines with respect to the storage, deletion and transfer of this data after your death. You can exercise these rights by contacting our Data Protection Officer at dpo.AICF@april.com.

Please return this form to APRIL International Care France enclosing a copy of your bank account details.

Creditor's use only

Send your application form by email:

myhealth.france@april-international.com

If you want to cancel your membership of the plan, you can use the tear-off slip below and send it to:
APRIL International Care France - Service Courrier (Mail Service) - 1 rue du Mont - CS 80010 - 81700 Blan - FRANCE

CANCELLATION

Article L.112-9 of the French Insurance Code

Any who is canvassed at their home or residence or place of work, or by means of distance communications such as telephone or internet, even 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 registered letter 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, please fill in and sign this tear-off slip. You should then send it in an envelope by registered letter with proof of receipt to the above address. It must be sent no later than 14 days from he day of signature of your Application or, where the deadline expires on a Saturday, Sunday or a public holiday or other non-working day, on the next working day.

I, the undersigned, wish to cancel my application for insurance under the following plan:

Plan name: **MyHealth France Ref. MHF Cov**

Policy number:

Client reference number:

Date of signature of Application form (DD/MM/YYYY): ☐☐/☐☐/☐☐☐☐

Member's last name:

Member's first name:

Member's date of birth: ☐☐/☐☐/☐☐☐☐

Member's address:

Postcode: City:

Country:

Telephone number: + ☐☐/☐☐☐☐☐☐☐☐☐

Name of insurance consultant:

Address of insurance consultant:

Postcode: City:

Country:

Telephone number: + ☐☐/☐☐☐☐☐☐☐☐☐

Date and member's signature:

☐☐/☐☐/☐☐☐☐

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 (MM/YY): ☐☐/☐☐

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 1, 2, 3 and 4.

B. Select your level of cover 5.

C. Indicate the date on which you want your cover to take effect 6.

D. Calculate your premium and indicate your selected payment method 7.

E. Date and sign your application in part 8.

F. If you wish to request a waiver of the waiting periods, that apply to the medical expenses cover please enclose the Exit certificate from your previous policy with details of your cover.

G. For the payment of your first premium, you can:
   - fill in the SEPA direct debit mandate at page 8 if you wish to make payments by direct debit from a bank account in Euros,
   OR
   - provide your credit/debit card details at page 10 of the Application form.

H. Join your bank details for your reimbursements.

I. For each person, a current Social Security certificate must be provided.

Send your application form and supporting documents to:
myhealth.france@april-international.com

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 start date of your policy.

Your policy will start on the date shown on the Membership certificate and, at the earliest, day following receipt of your Application form and supporting documents.

APRIL International Care France Head Office:

14 rue Gerty Archimède - 75012 Paris - FRANCE
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
NAF6622Z - VAT registration number: FR60309707727

april International
INSURANCE MADE EASY