MyHealth International
HEALTH QUESTIONNAIRE (1/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

VERY IMPORTANT

This Health questionnaire is valid for 3 months:

For example, if you want your contract to start on 01/04, you can sign this questionnaire between 01/01 and 31/03. Each insured must complete a questionnaire. If there are more than 2 people to be insured under the contract, please make a photocopy of the questionnaire.
Questions **6)** and **9)** do not apply to children.
Questions **3c)**, **3d)**, **4** and **7** do not have to be answered if you are applying for the Emergency package.

1 **ARTICLE L.113-8 OF THE FRENCH INSURANCE CODE: Irrespective of the ordinary causes of nullity and subject to the provisions of article L132- 26, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the insured member, when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the insured concealed or distorted has no impact on the claim.**

2 **PLEASE READ THE FOLLOWING QUESTIONNAIRE VERY CAREFULLY:** your attention is drawn to the importance of this questionnaire. All of the questions must be answered and the questionnaire must be signed and dated. 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 a hospital.

3 **CONFIDENTIALITY:** regardless of the responses given in this Health questionnaire, it is important to send it with your Application form, **in a sealed envelope marked "CONFIDENTIAL"** to the Medical Examiner, **together with any medical documents which will assist with the processing of your application**, at the address below:

APRIL International Care France
Service Courrier (mail service) - À l'attention du Médecin Conseil - 1 rue du Mont - CS 80010 - 81700 Blan - FRANCE

YOUR HEIGHT/WEIGHT: Centimeters Kilogrammes OR Inches Pounds

			TO BE COMPLETED IF YOU ANSWERED "YES" TO ONE OF THESE QUESTION
1	Before enrolling in this plan, were you or are you entitled to **100% French Social Security coverage** on medical grounds? If so, please mention the pathology. **If you are not concerned please tick "NO"**	☐ NO ☐ YES	*Reason:* *Date(s):* *Durations(s):*
2	During the last 10 years, have you been **hospitalised and/or undergone surgery** including by endoscopy (other than caesarean section, benign appendectomy, wisdom teeth, removal of tonsils or adenoids in childhood or any other)?	☐ NO ☐ YES	*Reason for hospitalisation:* *Date(s):* *Type of surgery:* *Date(s):* *Is treatment ongoing or scheduled?* ☐ NO ☐ YES *If YES, please provide details:*

MyHealth International
HEALTH QUESTIONNAIRE (2/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

3	**a)** During the last 5 years, have you consulted a doctor for a **bone, tendon, ligament, joint or rheumatic disorder, including disorders of the spine** (slipped disc, lumbago, cervicalgia, sciatica, or any other spinal disorder) or any fibromyalgia-type condition?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
	b) During the last 5 years, have you consulted a doctor regarding **psychiatric disorders** (e.g. anxiety, depression, overwork, burnout, psychosis or any other psychological and/or psychiatric disorders)?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
	c) During the last 5 years, have you consulted a doctor regarding a **cardiovascular condition** (e.g. high blood pressure, pulmonary embolism, heart rhythm disorder, heart attack, stroke, phlebitis) or any other cardiac and/or vascular conditions?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
	d) During the last 5 years, have you consulted a doctor regarding **respiratory disorders** (e.g. asthma, recurrent or chronic bronchitis or any other respiratory condition) other than acute seasonal disorders?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
4	Have you been tested for any of the following viruses: **human immunodeficiency virus (HIV), hepatitis B virus (HBV) Hepatitis C (HCV)**, with one of the results results indicating the mention **"POSITIVE"**?	☐ NO ☐ YES	*If YES, please provide details:* *Please provide date(s):*

MyHealth International
HEALTH QUESTIONNAIRE (3/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

5	**During the last 5 years,** have you **been prescribed any treatment or medication lasting more than 30 days?**	☐ NO ☐ YES	*Reason(s):* *Type of treatment:* *Date(s):* *Duration(s):*
6	**Are you currently, or over the last 5 years have you been, on medically-prescribed (total or partial) sick leave from work for more than 30 days** (excluding statutory maternity leave)?	☐ NO ☐ YES	*If* **YES**: *Illness* ☐ *Accident* ☐ *Type:* *Date(s):* *Duration(s):* *After-effects (if any):*
7	**Are you currently suffering from any illnesses and/or disorders,** or are you receiving any **follow-up medical care?**	☐ NO ☐ YES	*Type of illness or disorder:* *Date /Year of first symptoms:* *Type of follow-up care:* *From what date (DDMMYYYY):* / /
8	**Are you currently** being prescribed any **treatment or medication** lasting **more than 30 days or any regular treatment or medication?**	☐ NO ☐ YES	*Reason(s):* *Type of medical treatment:* *From what date (DDMMYYYY):* / /
9	**Do you have a pension,** annuity or allowance in respect of incapacity to work or a disability?	☐ NO ☐ YES	*Reason(s):* *From what date (DDMMYYYY):* / /
10	**Do you have** any deformities or disabilities?	☐ NO ☐ YES	*Reason(s):* *From what date (DDMMYYYY):* / /

MyHealth International
HEALTH QUESTIONNAIRE (4/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

11 IS IT PLANNED OVER THE NEXT 12 MONTHS FOR YOU TO:

a) have any medical tests (lab tests, medical imaging, endoscopy or any other medical examination)?	☐ NO ☐ YES	*Reason(s):* *Type of test:* *Date(s):*
b) have a consultation with a specialist?	☐ NON ☐ YES	*Reason(s):* *Date(s):*
c) undergo a surgical operation?	☐ NO ☐ YES	*Reason(s):* *Type of surgery:* *Date(s):*

Further details where the response to the question was YES:
To help us process your application, please provide us with as much detail as possible about the illnesses or conditions reported in the Health questionnaire. We would also recommend you enclose copies of **any MEDICAL REPORTS or ADDITIONAL DOCUMENTS** that may help our medical department process your application as quickly as possible: **hospital report, post-operative report, results and reports in respect of any additional examinations carried out (biological tests, imaging, specialist examinations, etc.), latest consultation reports, latest prescriptions, recent medical certificate, etc.**

Additional information:

Consequences of inaccurate or incomplete statements :
Before signing this health questionnaire, we invite you to reread your declarations with the utmost attention. Any omission on your part could result in a refusal to reimburse your health expenses and in the termination of your coverage.

I certify the accuracy and honesty of these statements. I expressly accept the collection and processing of my health data which is required for the management of my membership of the plan and my benefits. This data is processed in compliance with the rules of medical confidentiality. It is intended exclusively for the Medical Examiner, their medical department or for internal or external persons with specific authorisation. This data may also be used by authorised persons for the purposes of combatting fraud. I have the right to access, rectify and opt out by sending a letter by post, together with an identity document, to the Medical Examiner at the address shown in the letterhead.

Signed in (town or city) on (current date DDMMYYYY): / /

Signature of the insured member preceded by the words **"Read and approved"**:
Signature of the legal representative for insured children:

MyHealth International

Application form 2025

April International
INSURANCE MADE EASY

Updated: September 2024

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 following page or contact us.

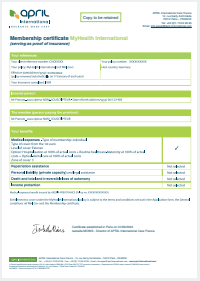
2

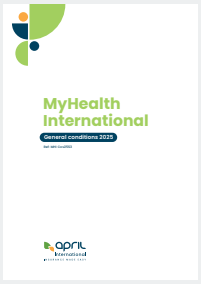
We process your application as soon as it arrives.

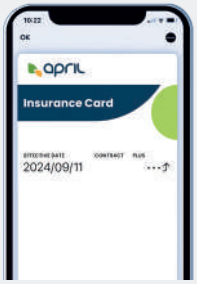
3

You will be sent:

- your Insurance certificate,
- 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. Enter your personal details 1, 2 and 3.

B. Choose the reimbursement method for your medical expenses 4.

C. Enter the date on which you want your cover to start 5.

D. Adjust your cover in section 6 and enter the required information in section 7.

E. Calculate your premium and specify your chosen payment method 8.

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

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

H. To pay your premium, you can:
- pay by a bank card,
- ***OR*** arrange a bank transfer (in this case, please enclose a copy of the transfer order).
- ***AND*** 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).

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

J. 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.

K. If you have taken out additional cover, please also send us the following supporting documents:
- for 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 €/$150: 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 e-mail:
info.expat@april-international.com

Insurance consultant reference number: I

MYHEALTH INTERNATIONAL Application form

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

PLEASE WRITE IN CAPITAL LETTERS

INSURED Person(s) to be insured

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

Surname of **principal insured**:

Birth name of the **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 ON YOUR CURRENT INTERNATIONAL HEALTH COVERAGE

◯ **No cover**

◯ **Health insurance scheme in the country of residence**

◯ **Private insurance**
- Name of insurer:
- Start date of your contract (MM/YYYY): /
- End date of your contract (MM/YYYY): /

1

Title of **spouse**: Ms ◯ Mr ◯ Date of birth (DDMMYYYY): / /

Surname of **spouse**:

Birth name of the **spouse**:

First name 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 dependant child**:

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

Date of birth (DDMMYYYY): / / Sex: Male ◯ Female ◯

Country of nationality:

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 dependant child**:

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

Date of birth (DDMMYYYY): ☐☐ / ☐☐ / ☐☐☐☐ Sex: Male ◯ Female ◯

Country of nationality:

Social Security number/CFE number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

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

Surname of **3rd dependant child**:

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

Date of birth (DDMMYYYY): ☐☐ / ☐☐ / ☐☐☐☐ Sex: Male ◯ Female ◯

Country of nationality:

Social Security number/CFE number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

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

Surname of **4th dependant child**:

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

1

Date of birth (DDMMYYYY): ☐☐ / ☐☐ / ☐☐☐☐ Sex: Male ◯ Female ◯

Country of nationality:

Social Security number/CFE number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

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

Surname of **5th dependant child**:

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

Date of birth (DDMMYYYY): ☐☐ / ☐☐ / ☐☐☐☐ Sex: Male ◯ Female ◯

Country of nationality:

Social Security number/CFE number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

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

Surname of **6th dependant child**:

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

Date of birth (DDMMYYYY): ☐☐ / ☐☐ / ☐☐☐☐ Sex: Male ◯ Female ◯

Country of nationality:

Social Security number/CFE number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Check digit: ☐☐

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

PRINCIPAL INSURED — Address for delivery of correspondance

2

Address:

Postcode: Town/city:

State/Region/Land/County:

Country:

Landline: + Mobile: +

Correspondance language: French ◯ English ◯ Spanish ◯ German ◯

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 ◯

Title: Ms ◯ Mr ◯

Surname:

Birth name:

First name:

Company ◯

Company name:

Title: Ms ◯ Mr ◯

Beneficial owner's surname:

Beneficial owner's birth name:

Beneficial owner's first name:

Please attach a copy of the document relative to the Beneficial owner.

3

Date of birth (DDMMYYYY): / /

Country of nationality:

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

4

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:

Additional code (ABA for a US account, BSB for an Australian account, etc):

Please attach an official document from your bank, confirming the bank details.

5

Cover start date (DDMMYYYY): ☐☐ / ☐☐ / ☐☐☐☐

(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.)

YOUR COVER:

► **COVERED COUNTRIES:**

Destination country:

Cover extension: ◯ Worldwide ◯ No extension

◯ Other countries:

► **CURRENCY:** ◯ € or ◯ US$ (available for cover from the 1st 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
- ◯ Cover as a top-up to the Caisse Nationale de Santé du Luxembourg

► **LEVEL OF HEALTHCARE COVER:**

6

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.*

► **DEDUCTIBLE AND LEVEL OF REIMBURSEMENT:**

DEDUCTIBLE	No deductible	€/US$500	€/US$1,000	€/US$2,500	€/US$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

► COVERED COUNTRY:

Your main destination:

Cover extension: ◯ Worldwide ◯ No extension ◯ Other countries:

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 9 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 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.

7

◯ 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

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

Principal insured

Net annual salary[1,2]: ◯ € ◯ $ Amount of daily benefit requested:

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

Is the principal insured in a business start-up situation? ◯ YES ◯ NO Deferred period: ◯ 30 days ◯ 60 days

Spouse

Net annual salary[1,2]: ◯ € ◯ $ Amount of daily benefit requested:

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

Is the spouse in a business start-up situation? ◯ YES ◯ NO Deferred period: ◯ 30 days ◯ 60 days

If you 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] *Mandatory fields.*
[2] *If you are starting or taking over a business, the monthly equivalent of the income protection benefit cannot exceed 70% of your previous net monthly salary.*
[3] *In this case the total amount of the daily benefits from the basic scheme and the MyHealth International plan combined cannot exceed 100% of net monthly salary.*

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**
CURRENCY	**Payment in € only**	◯ € ◯ $	◯ € ◯ $	◯ € ◯ $
		Payment in $ is only possible for plans with cover from the 1st US$		
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 instalments	◯	◯ €/$20 per quarter, or €/$80 per year	◯ €/$20 per quarter, or €/$80 per year	◯ €/$20 per quarter, or €/$80 per year
Monthly instalments	◯	—	—	—

8

▸ CALCULATING THE ANNUAL PREMIUM

Total 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: + 3 , 0 0

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.

For payment by bank transfer, credit card or PayPal, I have noted that it is my responsibility to make the payment at each split.

If you are paying by SEPA direct debit, please send us your bank account number and complete the SEPA direct debit mandate on page 16.

Paperless premium notices are sent by email and accessible 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 MHICovIPID and the General conditions (serving as the information notice, reference MHI Cov25S3) 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 ☐☐ / ☐☐ / ☐☐☐☐

(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.

MyHealth International
HEALTH QUESTIONNAIRE (1/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

VERY IMPORTANT

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Questions **3c)**, **3d)**, **4** and **7** do not have to be answered if you are applying for the Emergency package.

1 **ARTICLE L.113-8 OF THE FRENCH INSURANCE CODE: Irrespective of the ordinary causes of nullity and subject to the provisions of article L132- 26, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the insured member, when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the insured concealed or distorted has no impact on the claim.**

2 **PLEASE READ THE FOLLOWING QUESTIONNAIRE VERY CAREFULLY:** your attention is drawn to the importance of this questionnaire. All of the questions must be answered and the questionnaire must be signed and dated. 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 a hospital. Any change in the state of health between the date of signing the Health questionnaire and the effective date of the effective date of the coverage, must be communicated to our services.

3 **CONFIDENTIALITY:** regardless of the responses given in this Health questionnaire, it is important to send it with your Application form, **in a sealed envelope marked "CONFIDENTIAL"** to the Medical Examiner, **together with any medical documents which will assist with the processing of your application**, at the address below:

APRIL International Care France
Service Courrier (mail service) - À l'attention du Médecin Conseil - 1 rue du Mont - CS 80010 - 81700 Blan - FRANCE

YOUR HEIGHT/WEIGHT: Centimeters Kilogrammes OR Inches Pounds

			TO BE COMPLETED IF YOU ANSWERED "YES" TO ONE OF THESE QUESTION
1	Before enrolling in this plan, were you or are you entitled to **100% French Social Security coverage** on medical grounds? If so, please mention the pathology. **If you are not concerned please tick "NO"**	☐ NO ☐ YES	*Reason:* *Date(s):* *Durations(s):*
2	During the last 10 years, have you been **hospitalised and/or undergone surgery** including by endoscopy (other than caesarean section, benign appendectomy, wisdom teeth, removal of tonsils or adenoids in childhood or any other)?	☐ NO ☐ YES	*Reason for hospitalisation:* *Date(s):* *Type of surgery:* *Date(s):* *Is treatment ongoing or scheduled?* ☐ NO ☐ YES *If YES, please provide details:*

MyHealth International
HEALTH QUESTIONNAIRE (2/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

3	**a)** During the last 5 years, have you consulted a doctor for a **bone, tendon, ligament, joint or rheumatic disorder, including disorders of the spine** (slipped disc, lumbago, cervicalgia, sciatica, or any other spinal disorder) or any fibromyalgia-type condition?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
	b) During the last 5 years, have you consulted a doctor regarding **psychiatric disorders** (e.g. anxiety, depression, overwork, burnout, psychosis or any other psychological and/or psychiatric disorders)?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
	c) During the last 5 years, have you consulted a doctor regarding a **cardiovascular condition** (e.g. high blood pressure, pulmonary embolism, heart rhythm disorder, heart attack, stroke, phlebitis) or any other cardiac and/or vascular conditions?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
	d) During the last 5 years, have you consulted a doctor regarding **respiratory disorders** (e.g. asthma, recurrent or chronic bronchitis or any other respiratory condition) other than acute seasonal disorders?	☐ NO ☐ YES	*Please specify the condition and the prescribed treatment and/or medication:* *Date(s):* ***Is treatment ongoing or scheduled?*** ☐ NO ☐ YES *If YES, please provide details:*
4	Have you been tested for any of the following viruses: **human immunodeficiency virus (HIV), hepatitis B virus (HBV) Hepatitis C (HCV)**, with one of the results results indicating the mention **"POSITIVE"**?	☐ NO ☐ YES	*If YES, please provide details:* *Please provide date(s):*

MyHealth International
HEALTH QUESTIONNAIRE (3/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

5	**During the last 5 years,** have you **been prescribed any treatment or medication lasting more than 30 days?**	☐ NO ☐ YES	*Reason(s):* *Type of treatment:* *Date(s):* *Duration(s):*
6	**Are you currently, or over the last 5 years have you been, on medically-prescribed (total or partial) sick leave from work for more than 30 days** (excluding statutory maternity leave)?	☐ NO ☐ YES	*If* **YES**: *Illness* ☐ *Accident* ☐ *Type:* *Date(s):* *Duration(s):* *After-effects (if any):*
7	**Are you currently suffering from any illnesses and/or disorders,** or are you receiving any **follow-up medical care?**	☐ NO ☐ YES	*Type of illness or disorder:* *Date /Year of first symptoms:* *Type of follow-up care:* *From what date (DDMMYYYY):* / /
8	**Are you currently** being prescribed any **treatment or medication** lasting **more than 30 days or any regular treatment or medication?**	☐ NO ☐ YES	*Reason(s):* *Type of medical treatment:* *From what date (DDMMYYYY):* / /
9	**Do you have a pension,** annuity or allowance in respect of incapacity to work or a disability?	☐ NO ☐ YES	*Reason(s):* *From what date (DDMMYYYY):* / /
10	**Do you have** any deformities or disabilities?	☐ NO ☐ YES	*Reason(s):* *From what date (DDMMYYYY):* / /

MyHealth International
HEALTH QUESTIONNAIRE (4/4)

Surname: Birth name: First name(s):

Date of birth (DDMMYYYY): / / Country of nationality:

11 IS IT PLANNED OVER THE NEXT 12 MONTHS FOR YOU TO:

a) have any medical tests (lab tests, medical imaging, endoscopy or any other medical examination)?	☐ NO ☐ YES	*Reason(s):* *Type of test:* *Date(s):*
b) have a consultation with a specialist?	☐ NON ☐ YES	*Reason(s):* *Date(s):*
c) undergo a surgical operation?	☐ NO ☐ YES	*Reason(s):* *Type of surgery:* *Date(s):*

Further details where the response to the question was YES:
To help us process your application, please provide us with as much detail as possible about the illnesses or conditions reported in the Health questionnaire. We would also recommend you enclose copies of **any MEDICAL REPORTS or ADDITIONAL DOCUMENTS** that may help our medical department process your application as quickly as possible: **hospital report, post-operative report, results and reports in respect of any additional examinations carried out (biological tests, imaging, specialist examinations, etc.), latest consultation reports, latest prescriptions, recent medical certificate, etc.**

Additional information:

Consequences of inaccurate or incomplete statements :
Before signing this health questionnaire, we invite you to reread your declarations with the utmost attention. Any omission on your part could result in a refusal to reimburse your health expenses and in the termination of your coverage.

I certify the accuracy and honesty of these statements. I expressly accept the collection and processing of my health data which is required for the management of my membership of the plan and my benefits. This data is processed in compliance with the rules of medical confidentiality. It is intended exclusively for the Medical Examiner, their medical department or for internal or external persons with specific authorisation. This data may also be used by authorised persons for the purposes of combatting fraud. I have the right to access, rectify and opt out by sending a letter by post, together with an identity document, to the Medical Examiner at the address shown in the letterhead.

Signed in (town or city) on (current date DDMMYYYY): / /

Signature of the insured member preceded by the words **"Read and approved"**:
Signature of the legal representative for insured children:

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 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 (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 Cov25S3**

Policy number:

Client reference number:

Date of signature of Application form (DDMMYYYY): ☐☐ / ☐☐ / ☐☐☐☐

Member's surname:

Member's first name:

Member's date of birth: ☐☐ / ☐☐ / ☐☐☐☐

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:

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 APRIL International Care France to send instructions to your bank to debit your account and 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 payment* (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)*: / /

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.

Signature*:

Creditor's use only

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APRIL International Care France Head Office:

14 rue Gerty Archimède - 75012 Paris - FRANCE
www.april-international.com

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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).
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