[LA MOBILITÉ]
INDIVIDUALS

Asia Expat

Application form 2011

Creating a new face of insurance.

Asia Expat Application form

PLEASE WRITE IN CAPITAL LETTERS

Insurance consultant reference number: I

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

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

Surname of **principal insured**:

First names of **principal insured**:

Date of birth: d d / m m / y y y y

Country of nationality:

Host country:

Occupation:

E-mail:

(providing en email address will allow you to receive information on your reimbursements)

Marital status of **spouse**: Mrs ◯ Miss ◯ Mr ◯

Surname of **spouse**:

First names of **spouse**:

Date of birth: d d / m m / y y y y

Country of nationality:

Host country:

Occupation:

1

Surname of **1st dependent** child:

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

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

Surname of **2nd dependent** child:

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

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

Surname of **3rd dependent** child:

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

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

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

PRINCIPAL INSURED — Address for delivery of correspondence

2

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

Street name:

Postcode: Town or city:

State / Region / Canton / Land / County:

Country:

Telephone: / / / / / *if outside France*

My language of choice of correspondence is: french ◯ english ◯

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**

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Individual ◯ **Corporate** ◯ Name of company:

Title: Mrs ◯ Miss ◯ Mr ◯ Date of birth: d d / m m / y y y y

Surname:

First names:

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

Street name:

Postcode: Town or city:

State / Region / Canton / Land / County:

Country:

Telephone: / / / / / *if outside France*

E-mail:
(providing us with an email address means we can send you information on your policy)

My language of choice of correspondence is: french ◯ english ◯

During your period of insurance you can update your contact details at www.aprilmobilite.com (Individuals).

CHOICE OF BENEFITS AND LEVEL OF COVER:

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4.1 / Medical expenses cover

Membership: ◯ individual ◯ family **Option**: ◯ BASIC ◯ ADVANCED

The level of the family premium depends on the age of the eldest person.

Annual premium (all taxes included): USD A

Your reimbursement statements are available by email or on your insurance website. If you would also like to receive a paper version, please tick this box: ◯

4.2 / Repatriation assistance cover

Membership: ◯ individual ◯ family Annual premium (all taxes included): USD B

4.3 / Death and total and irreversible loss of autonomy

• INDIVIDUAL MEMBERSHIP ONLY

Depending on the level of benefit selected, certain medical formalities may be required. Please refer to page 9 of the brochure.

Principal insured

Amount of cover requested (between USD 20,000 and USD 400,000): USD ☐☐☐☐☐☐ (amount doubled in case of death by accident)

Annual premium (all taxes included): USD ☐☐☐☐☐.☐☐ C

Spouse

Amount of cover requested (between USD 20,000 and USD 400,000): USD ☐☐☐☐☐☐ (amount doubled in case of death by accident)

Annual premium (all taxes included): USD ☐☐☐☐☐.☐☐ D

• NAME OF BENEFICIARIES

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

◯ My surviving spouse on condition that we were not legally separated when the lump sum became payable, second, equally, to my children living, to be born or represented as such; third, equally to my ascendants and fourth to my other heirs.

◯ Other beneficiary: Name:........................ First names:........................

Date of birth: d d / m m / y y y y Place of birth: ....

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

◯ My surviving spouse on condition that we were not legally separated when the lump sum became payable, second, equally, to my children living, to be born or represented as such; third, equally to my ascendants and fourth to my other heirs.

◯ Other beneficiary: Name........................ First names:........................

Date of birth: d d / m m / y y y y Place of birth: ....

4.4 / Sick leave from work

(must be combined with death and total and irreversible loss of autonomy cover ; the amount of the daily allowance depends on the level of death benefits you have selected ➔ For example, to receive USD 20 per day, you must have selected death benefits of at least USD 20,000)

• INDIVIDUAL MEMBERSHIP ONLY

Depending on the level selected, certain medical formalities may be required. Please see page 10 of the brochure.

Principal insured

Gross annual salary*: USD ☐☐☐☐☐☐

Amount of daily allowance requested (between USD 20 and USD 200): USD ☐☐☐

Excess: ◯ 30 days ◯ 60 days

Corresponding death benefits: USD ☐☐☐☐☐☐

Annual premium (all taxes included): USD ☐☐☐☐☐.☐☐ E

Spouse

Gross annual salary*: USD ☐☐☐☐☐☐

Amount of daily allowance requested (between USD 20 and USD 200): USD ☐☐☐

Excess: ◯ 30 days ◯ 60 days

Corresponding death benefits: USD ☐☐☐☐☐☐

Annual premium (all taxes included): USD ☐☐☐☐☐.☐☐ F

* compulsory fields

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Choice of start date: dd / mm /2011 (1st or 16th of the month)

(subject to your application being approved and at the earliest on the 16th of the month or the first day of the month following receipt of the Application form)

Calculating and paying the premium

Select the number of instalments of the premium	Tick your chosen payment method:	
	Bank transfer*	Cheque*
Annual instalment charges	◯	◯
Twice yearly instalment charges	◯ USD 20 per semester or USD 40 per year	* If I choose any of these two payment methods, it is my responsibility to ensure payment is made for each instalment
Quarterly instalment charges	◯ USD 20 per quarter or USD 80 per year	

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Calculating the premium

Total annual premiums (all taxes included): A + B + C + D + E + F : USD ☐☐☐☐☐.☐☐ G

Annual membership fees in addition to cover selected: + USD 24.00 H

Annual instalment charges if payment is quarterly or twice yearly: + USD ☐☐.☐☐ I

Total premium for 12 months:* G + H + I : USD ☐☐☐☐☐.☐☐ J

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

Total amount of 1st premium: USD ☐☐☐☐☐.☐☐

If you want your policy to take effect on the 16th of the month, you should divide the first monthly premium by two. The first premium is a pro rata amount of the annual premium which is valid until 31/12/2011. When calculating your premium, remember to include the instalment charge if applicable.

Paying the premium:

I will pay my first premium by cheque or postal order made **payable to APRIL Mobilité** or by bank transfer.

I will pay future premiums by cheque or postal order or bank transfer. For these two payment methods, I understand that it is my responsibility to make the payments when they are due.

Paperless premium notices are available by email or on your insurance website. If you would also like to receive a paper version, please tick the following box: ◯

SIGNATURE OF THE APPLICATON

I hereby apply for membership of the Association of APRIL Mobilité Insured under their agreements with Axéria Prévoyance and ACE Europe for the insured listed on the Application form. I have read the Association's statutes and regulations.

I have read the General conditions and booklet As 2011 outlining the details of my insurance cover. I am aware of my right to cancel the insurance and accept the terms and conditions. I have retained a copy of these.

I also understand the terms and conditions of APRIL 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 French Act of 6th 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, CS 51108, 75127 Paris Cedex 11, 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.

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Under the French Act of 6th 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 understand that cover under the present policy does not exempt me from paying contributions to any state scheme to which I may belong.

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 present policy.

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

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

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Validity of the Health questionnaire: 6 months
Example: if you would like your policy to start on 01/07/2011, you can sign this questionnaire between 01/01/2011 and 30/06/2011

You must personally answer all the questions as accurately as possible as your responses are binding. This Health questionnaire is essential to the evaluation of the risk that the insurer proposes to undertake. Any unanswered questions will result in further enquiries.

Any medical information you provide is held in strict confidence. Detailed answers will help us process your application promptly.

To ensure your responses remain confidential, please send the Health questionnaire and all supporting documentation in a sealed envelope for the attention of APRIL Mobilité's Medical Examiner.

Some of the medical information you provide may be processed electronically for the use of the APRIL Mobilité's Medical Examiner.

Under the French Act of 6th January 1978, you have the right to access and, if necessary, rectify any personal information held on file by writing to the Medical Examiner, APRIL Mobilité - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

QUESTION:	Principal insured	Spouse	1st dependent child	2nd dependent child	3rd dependent child
1 Height					
2 Weight					
3 Are you currently on partial or total sick leave from work due to illness or accident?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
4 Within the **last 10 years,** have you:					
a) undergone surgery?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
b) undergone laser treatment, chemotherapy or radiation therapy?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
5 Within the **last 5 years,** have you had an illnesss or an accident which result in:					
a) more than one month's sick leave from work?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
b) more than one month's medical treatment?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
6 Within the **last 5 years,** have you consulted for:					
a) nervous conditions (chronic fatigue, anxiety, depression)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
b) back complaints (back pain, sciatica, slipped disc)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
c) arthritis and/or rheumatism (hip, knee, shoulder...)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO

confidential

QUESTIONS (CONTINUED):	Principal insured	Spouse	1st dependent child	2nd dependent child	3rd dependent child
7 Do you suffer from any disorder or illness requiring or not regular medical supervision or treatment?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
8 Have you been tested for HBV (Hepatitis B)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
If you answered "**Yes**" to this question, were the results positive?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Date of the test:					
8 Bis Have you been tested for HCV (Hepatitis C)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
If you answered "**Yes**" to this question, were the results positive?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Date of the test:					
8 Ter Have you been tested for HIV (AIDS)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
If you answered "**Yes**" to this question, were the results positive?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Date of the test:					
9 Do you have a disability which entitles you to benefits?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
10 Will you undergo any diagnostic test **over the next 6 months** (lab tests, scans, endoscopy...) and/or have a consultation with a specialist and/or any treatment or surgery?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
11 Within the **last 12 months,** have you had:					
a) more than 3 periods of sick leave of any duration?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
b) specialist tests (other than routine screening) such as lab tests, scans, endoscopy...?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
12 Do you have, or have you ever had 100% cover from Social Security for a long-term complaint (with no contribution from you towards costs)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
13 Do you want your responses to this Health questionnaire to remain confidential?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO

confidential

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 Medical Examiner to the following address: APRIL Mobilité - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Further details if the response to one of the questions is YES (other than question 13):
To help us process your application, 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 insurers of the present policy.

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

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

Signatures of the insured spouse preceded by the words **"I have read, understood and accepted the policy document"**:

Signature(s) of the insured dependent child(ren) over 18 preceded by the words **"I have read, understood and accepted the policy document"**:

Your Insurance consultant + APRIL Mobilité Code:

I

April Medibroker
Unit 4, Rake House Farm, Rake Lane, North Shields
Tyne & Wear, NE29 8EQ
United Kingdom

Tel: +44 (0) 191 296 6140 Fax: +44 (0) 191 257 6272
Email: clientservices@medibroker.com

Please send your completed application to:

APRIL Mobilité
Service Adhésions Individuelles
110, avenue de la République - CS 51108
75127 Paris Cedex 11 - FRANCE

To cancel your policy, please use the tear-off slip below and send it to:
APRIL Mobilité - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

CANCELLATION OF DOOR-TO-DOOR CONTRACT OF SALE

Articles L121.23 to L 121.26 of the French Consumer Code

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 by registered letter with proof of receipt to the above address. It must be sent no later than 14 days (legal time limit of 7 days extended to 14 days by the insurers) 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: **Asia Expat Ref. As 2011**

Date of signature of application: d d / m m / y y y y

Member's surname:

Member's first name:

Date of birth: d d / m m / y y y y

Member's address:

Postcode: City:

Country:

Telephone: / / / / / *if outside France*

Name of insurance consultant:

Address of insurance consultant:

Postcode: City:

Country:

Telephone: / / / / / *if outside France*

Date and member's signature:

d d / m m / y y y y

Reserved for APRIL Mobilité

Client reference number C

Article L121-23

The transactions referred to in article L.121-21 must be the subject of a contract, a copy of which must be sent to the client when the contract is concluded and must include the following information: otherwise they are null and void:

1 - Names of supplier and canvasser;
2 - Address of supplier;
3 - Address of the place where the contract was concluded;
4 - Precise description of the nature and characteristics of the goods offered or the services proposed;
5 - Contract performance terms, in particular delivery procedures and deadlines for goods or performance procedures and deadlines for services;
6 - Overall price to pay and payment methods; in the event of sales on instalment credit terms or on credit, the forms required by credit sales regulations, as well as the nominal rate of interest and the annual percentage rate of interest determined in accordance with the conditions provided for in article L.313-1;
7 - Option of cancellation provided for in article L.121-25, as well as the conditions under which said option may be exercised and, clearly stated, the full text of articles L.121-23, L.121-24, L.121-25 and L.121-26.

Article L121-24

The contract referred to in article L. 121-23 must include a detachable form intended to facilitate the exercising of the option of waiver in accordance with the conditions provided for in article L 121-25. A Council of State decree will specify the wording which must appear on this form.
This contract may not include any jurisdictional clause.
All copies of this contract must be signed and dated by the client, in person.

Article L121-25

Within seven days, including bank holidays, of the order or the undertaking to buy, the customer has the right to cancel by means of a registered letter with proof of receipt. If this deadline normally expires on a Saturday, Sunday, bank holiday or non-working day, it is extended until the next working day.
Any contractual clause by virtue of which the customer waives his/her right to cancel his/her order or his/her undertaking to buy is null and void.
This article does not apply to contracts concluded under the circumstances provided for in article L.121-27.

Article L121-26

Prior to the expiry of the cooling-off period provided for in article L.121-25, nothing may be requested or obtained from the customer, directly or indirectly, on any grounds or in any form whatsoever nor any consideration or undertaking nor the provision of services of any kind whatsoever.
Home subscription to a daily, or similar, publication in the sense of article 39a of the general tax code is not, however, subject to the provisions of the previous paragraph provided that the consumer has a permanent right to cancel, without expense or compensation, together with reimbursement, within fifteen days, of sums paid, on a pro-rata basis, for the subscription period still to run.
In addition, payment obligations or orders must not be executed prior to the expiry of the deadline provided for in article L.121-25 and must be returned to the consumer within fifteen days of cancellation.
The provisions of the second paragraph apply to subscriptions taken out at home offered by State-approved associations and companies with the object of providing services referred to in Article L.129-1 of the Labour Code Article L121-23.

TAKING OUT THE INSURANCE

A. Fill in your personal details (surname, first name, address…) 1, 2 and 3.

B. Select your level of cover 4.

C. Indicate the date on which you want your cover to take effect 5.

D. Indicate the number of instalments and your selected payment method. Then calculate your premium 6.

E. Date and sign your application in part 7.

F. Date, complete and sign the Health questionnaire 8.

G. Enclose payment of the first premium by cheque or by bank tranfer.

Send your application form and supporting documents to:
APRIL Mobilité - Service Adhésions Individuelles
110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

WHAT HAPPENS NEXT?

Your application is processed within 24 hours, as soon as we receive your application form and supporting documents.

Your insurance is evidenced by a Membership certificate showing details of your level of cover and the start date of your policy.

Your policy will start on the date shown on the Membership certificate and, at the earliest, on the 16th of the month or the first day of the month following receipt of your application form and supporting documents.

april | mobilité

APRIL MOBILITÉ A MEMBER OF APRIL
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Registered with Companies House in Paris under number 309 707 727
Insurance broker - Registered with ORIAS (Organisation for the registration of insurance brokers) under number 07 008 000 (www.orias.fr)
Prudential Supervision Authority - 61, rue Taitbout - 75436 Paris Cedex 09 - FRANCE

Creating a new face of insurance.

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