APPLICATION FORM
2017

ASIA HEALTH PLAN

april international

ASIA HEALTH PLAN APPLICATION FORM

Insurance consultant reference number: I 61837

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

PLEASE WRITE IN CAPITAL LETTERS

INSURED Person(s) to be insured

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

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

Anticipated length of expatriation: years

Occupation:

Business sector:

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

Email:

1

Title of **spouse:** Mrs ◯ 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:

Business sector:

Is your spouse, or any of their family members, a Politically Exposed Person*? YES ◯ NO ◯

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 ◯

*Person residing outside France who holds or has within the last year held a prominent political, judicial or administrative position in a country other than France, or on behalf of a public international body.

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.
If you would also like to receive a paper version, please tick this box: ◯
Your insurance card will be sent by post.

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

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**

3

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

Title: Mrs ◯ Mr ◯

Surname:

First names:

Address:

Postcode: City:

State/Region/Land/County:

Country:

Landline: + / Mobile: + /

Email:

CHOICE OF BENEFITS AND LEVELS OF COVER

4

4.1 / Medical expenses cover

Option: ◯ ESSENTIAL ◯ COMFORT

Level of annual excess: ◯ USD 0/year ◯ USD 500/year ◯ USD 1,500/year ◯ USD 5,000/year

> **Premium principal insured:** USD

> **Premium spouse:** USD

> **Premium child(ren) <21 years old:** USD X child(ren) = USD

> **Premium child(ren) 21-25 years old:** USD X child(ren) = USD

▸ **Annual premium (all taxes included)**: USD . Ⓐ

For medical expenses you can choose to be reimbursed by:

◯ transfer to a bank account in USD in the US (international bank details are required including the account number, SWIFT code, your bank's address, sort code and the ABA routing number)
◯ transfer to a bank account in USD in another country (international bank details are required including the account number, SWIFT code and your bank's address)

Depending on the location of your bank account, additional fees might be charged by your bank.

4.2 / Repatriation assistance cover

Membership: ◯ individual ◯ 2 individuals ◯ family (3 or more individuals)

▸ **Annual premium (all taxes included)**: USD Ⓑ

5 Choice of effective date: d d / m m /2017 (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 PAYMENT FREQUENCY:	Tick your chosen payment method:	
	Credit or debit card*	Bank transfer*
	* I understand that it is my responsibility to ensure payment is made for each instalment	
Annually	◯	◯
Twice yearly	◯ USD 20 per semester or USD 40 per year	◯ USD 20 per semester or USD 40 per year
Quarterly	◯ USD 20 per quarter or USD 80 per year	◯ USD 20 per quarter or USD 80 per year

Calculating the annual premium

Total annual premiums (all taxes included): A + B: USD . C

6 Annual membership fee of the Association des Assurés d'APRIL International in addition to selected benefits: + USD 4.00 D

Annual management fee in addition to selected benefits: + USD 20.00 E

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

Total premiums* for 12 months: C + D + E + F: USD . G

* 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 to pay your premium twice yearly or quarterly, the amount of your 1st premium corresponds to the annual premium G divided by 2 or 4 respectively.

Paying the first premium:

◯ **by bank transfer:**
Account holder: **APRIL International Expat**
IBAN: FR02 3000 2019 5800 0006 2048 H25
BIC / Swift code: CRLYFRPPXXX

◯ **by credit or debit card** (Eurocard-Mastercard and Visa only)

Please provide your card details using the box on page 17.

Paying future premiums by cheque, bank transfer or credit/debit card. For these three 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 in your online Customer zone. If you would also like to receive a paper version, please tick the following box: ◯

SIGNATURE OF THE APPLICATION

I hereby apply for membership of the Association des Assurés d'APRIL International under their agreements with Groupama Gan Vie for medical expenses cover (plan number 219/863685) and CHUBB for repatriation assistance cover (plan number FRBBBAO1857), for the insured members listed on the Application form. I have read the Association's statutes and regulations (available to download at http://en.april-international.com/global/april-international-expat/association-of-april-international-insured).

I have read the General conditions AHP Cov 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 International Expat'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.

APRIL International Expat may contact me by telephone regarding my application for insurance unless I opt out by sending an email to: membership.expat@april-international.com or by post to the address below.

In application of Article L121-34 of the French Consumer Code, I have the right to opt out of marketing calls and can exercise this right by contacting Opposetel at: http: //www.bloctel.gouv.fr.

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 International Expat, the insurers or their agents for the requirements of my insurance cover.

Under the French Act of 6th January 1978 (amended), I have the right to access and, if necessary, rectify any personal information held on file by writing to APRIL International Expat, 110 avenue de la République, CS 51108, 75127 Paris Cedex 11, FRANCE. APRIL International Expat has the right to utilise certain administrative information and to share it with the APRIL group subsidiaries who may use it to make me aware of new products or services.

Under the French Act of 6th January 1978 (amended), I have the right to prevent my details being passed on in this way by writing to APRIL International Expat at the above address. Postal charges will be refunded.

Furthermore, in order to meet its legal obligations, APRIL International Expat is implementing a monitoring procedure the purpose of which is to combat money laundering and the financing of terrorism, and the application of financial penalties. In accordance with article L561-45 of the French Monetary and Financial Code, I can exercise my right of access by applying to the French Data Protection Agency, Commission Nationale Informatique et Libertés, 8 rue Vivienne, CS 30223, 75083 Paris Cedex 02, FRANCE. However, if the request is in connection with the procedure introduced for the purpose of identifying persons whose assets have been frozen or on whom a financial penalty has been imposed under the French Data Protection Act 78-17 of 6th January 1978, I can exercise my right of access by sending a letter, together with a copy of my ID, to APRIL International Expat, 110 avenue de la République, CS 51108, 75127, Paris Cedex 11, FRANCE.

7 I understand that telephone calls to APRIL International Expat may be recorded for administrative purposes and that I may have access to recordings made of my calls by writing to APRIL International Expat 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 and that some benefits are subject to the application of waiting periods.

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

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 Expat requires me to declare any similar insurance cover which I may have purchased from other insurers.

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

I authorise APRIL International Expat and my treating doctors to exchange any information, including medical details, required for the management of my claims.

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) _____ Date d d / m m / y y y y

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"**:

To insure children under 18, the member must sign the Application form and be a parent, legal guardian or person exercising parental authority.

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER

1

This Health questionnaire is valid for 3 months.

For example, if you want your policy to start on 01/07/2017, you can sign the questionnaire between 01/04/2017 and 30/06/2017.
Each insured person must complete a Health questionnaire. Questions **1, 2a), 2b)** and **15** are not required for minor children.
If the policy covers more than 2 people, please photocopy the questionnaire.

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.

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 hospital.

If you wish your answers to remain confidential, detach this 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 International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Some of the medical information you provide may be processed electronically for the use of the APRIL International Expat's Medical Examiner. Under the French Act of 6th January 1978 (amended), you have the right to access and, if necessary, rectify any personal information held on file by writing to the APRIL International Expat's Medical Examiner at the above address.

SURNAME: ..... FIRST NAME(S): .....

DATE OF BIRTH: |_|_| |_|_| |_|_|_|_| HEIGHT: |_|_|_| cm WEIGHT: |_|_|_| kg

1	a) Do you drink alcohol?		Low alcohol drinks: ..... glasses/day ; Spirits: ..... drinks/day
	b) Do you smoke or have you smoked in the past pipes, cigars or cigarettes?	◯ YES ◯ NO	If so, how many per day? Pipes ..... Cigars ..... Cigarettes ..... Electronic cigarette ◯ For how many years? ..... years
	If you quit smoking, please state when and why:		Year: |_|_| |_|_| |_|_|_|_| Reason: .....
2	a) Are you **currently on total or partial sick leave from work**?	◯ YES ◯ NO	Reason: ..... Start date: |_|_| |_|_| |_|_|_|_|
	b) **During the last 10 years**, have you had any periods of **total or partial sick leave from work** lasting more than 15 days?	◯ YES ◯ NO	Reason: ..... Start date: |_|_| |_|_| |_|_|_|_| End date: |_|_| |_|_| |_|_|_|_|
	c) Do you have a recognised **infirmity** or **total or partial disability/incapacity**?	◯ YES ◯ NO	Please specify: ..... Start date: |_|_| |_|_| |_|_|_|_| Origin or cause: ..... Percentage of permanent incapacity or disability: |_|_| %
3	Do you have a **congenital or hereditary disorder**?	◯ YES ◯ NO	Illness: ..... Treatment and/or follow-up: ..... Date of diagnosis: |_|_| |_|_| |_|_|_|_|
4	Have you ever had an **accident** which caused **after-effects**?	◯ YES ◯ NO	Date of accident: |_|_| |_|_| |_|_|_|_| Location of after-effects: ..... Nature of after-effects: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER (CONTINUED)

1

5	a) Are you **currently** having any **medical or paramedical treatment** (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Duration of treatment: .....
	b) **During the last 5 years,** have you had **any medical or paramedical treatment** (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment) lasting more than 15 days?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Duration of treatment: .....
6	During the last 10 years, have you been **admitted** to a **medical facility**, including for periods of less than 24 hours (clinic, hospital, care home, psychiatric unit) for: - an operation or medical or surgical procedure (endoscopy, biopsy, arthroscopy, angioplasty), - specialist examinations and tests, - treatment, - convalescence, - addiction treatment, - rehabilitation, excluding surgery on wisdom teeth, tonsils and adenoids and for appendicitis?	◯ YES ◯ NO	Date: __/__/____ Reason for admission: .... Length of stay: .... Results: .... Prescribed treatment: ....
7	During the last 5 years, have you had any **laboratory tests** (blood, urine or stools), **cardiology tests** (ultrasound, ECG, Doppler, Holter) and/or **medical imaging** (ultrasound, scans, PET scans, scintigraphy, MRI, endoscopy, colonoscopy, gastroscopy, radiology or mammogram)?	◯ YES ◯ NO	Date: __/__/____ Type of test: ..... Reason for test: ..... Results : ..... Prescribed treatment: .....
8	Over the last 12 months, have you had your blood pressure checked by a doctor?	◯ YES ◯ NO	If yes, what were the results? ....
9	**Do you currently suffer or have you suffered over the last 10 years from the following types of illness:**		
	a) **Respiratory** (asthma, chronic bronchitis, tuberculosis, respiratory failure or any other respiratory disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	b) **Cardiovascular** (high blood pressure, phlebitis, heart attack, stroke or any other cardiovascular disorders)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	c) **Ophthalmic/ENT** (glaucoma, cataract, blindness (even if in one eye), deafness or any other eye or ENT disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	d) **Articular** (cervicalgia, slipped disc, sciatica, lumbago, polyarthritis or any other disorder of the bones or joints or autoimmune diseases)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER (CONTINUED)

9	**Do you currently suffer or have you suffered over the last 10 years from the following types of illness:**		
	e) **Dermatological** (eczema, psoriasis, lupus or any other dermatological condition)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	f) **Digestive** (Crohn's disease, ulcerative colitis, oesophageal varices, liver disease, pancreatic disease or any other digestive disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	g) **Neuromuscular** (epilepsy, myopathy, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia or any other disorder of the nervous or muscular system)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	h) **Metabolic and endocrine** (thyroid, diabetes, cholesterol, pituitary disease or any other disorder of the metabolic or endocrine system)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	i) **Urinary and renal** (kidney disease, urinary tract disease or any other disorders of the urinary and renal system)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	j) **Genital** (endometriosis, prostate disease or any other gynecological or urogenital disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	k) **Nervous** (depression, stress, anxiety, neuroses, psychoses, fibromyalgia, eating disorders or any other psychological or psychiatric disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	l) **Tumour/Cancer** (leukemia, Hodgkin's disease, lymphoma, benign and/or malignant tumours or any other cancerous disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	m) **Other** infectious, viral, parasitic or haematological **diseases**, malaria, hepatitis or disorders requiring medical supervision?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
10	Have you been screened for hepatitis B and C or the human immunodeficiency virus (HIV), **where the result was positive**?	◯ YES ◯ NO	Virus: ..... Date of test: __/__/____ *(you only need to answer YES to this question if the result of one of the tests was positive)*
11	Are you being **monitored by a specialist**?	◯ YES ◯ NO	Reason: ..... Start date of the illness: __/__/____ Treatment(s): .....

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HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER (CONTINUED)

1

12	In the last six months, have you had any diagnostic tests (lab tests, medical imaging) **or additional medical examinations**?	◯ YES ◯ NO	Reason: .... Type of examination or tests: ..... Date: __/__/____ Results: .....
13	Is it planned over the next 6 months for you to have **any medical tests** (lab tests, medical imaging, endoscopy or any other medical test), **consult a medical specialist or undergo any medical or surgical treatment**?	◯ YES ◯ NO	Reason: ..... Date of scheduled tests: __/__/____ Nature of scheduled tests: ..... Date of planned treatment: __/__/____ Type of planned treatment: ..... Length of planned treatment: ..... Specialty of the doctor consulted: .....
14	Is it planned within 12 months of the effective date of your insurance policy for you to be **admitted to hospital**, **including as an outpatient** (knee surgery, removal of cyst, childbirth or for any other reason)?	◯ YES ◯ NO	Reason: .... Scheduled date: __/__/____ Length of stay: .....
15	In the last 5 years have you **been accepted for insurance subject to exclusions or additional premiums, or had cover denied or cancelled** by the insurer of a healthcare or death & disability insurance policy (daily sick leave allowance, disability, death)?	◯ YES ◯ NO	Reason for cancellation, additional premium or denial of cover: ....

Details if you answered YES to any of the questions:

8 To help us process your application, you can provide additional details about your health condition.

ADDITIONAL INFORMATION .....

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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 insured preceded by the words **"I have read, understood and accepted the policy document"**:
Signature of the father, mother or legal guardian for insured children under 18:

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER 2

This Health questionnaire is valid for 3 months.

For example, if you want your policy to start on 01/07/2017, you can sign the questionnaire between 01/04/2017 and 30/06/2017.
Each insured person must complete a Health questionnaire. Questions **1, 2a), 2b)** and **15** are not required for minor children.
If the policy covers more than 2 people, please photocopy the questionnaire.

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.

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 hospital.

If you wish your answers to remain confidential, detach this 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 International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE.

Some of the medical information you provide may be processed electronically for the use of the APRIL International Expat's Medical Examiner. Under the French Act of 6th January 1978 (amended), you have the right to access and, if necessary, rectify any personal information held on file by writing to the APRIL International Expat's Medical Examiner at the above address.

SURNAME: ..... FIRST NAME(S): .....

DATE OF BIRTH: |_|_| |_|_| |_|_|_|_| HEIGHT: |_|_|_| cm WEIGHT: |_|_|_| kg

1	a) Do you drink alcohol?		Low alcohol drinks: ..... glasses/day ; Spirits: ..... drinks/day
	b) Do you smoke or have you smoked in the past pipes, cigars or cigarettes?	◯ YES ◯ NO	If so, how many per day? Pipes ..... Cigars ..... Cigarettes ..... Electronic cigarette ◯ For how many years? ..... years
	If you quit smoking, please state when and why:		Year: |_|_| |_|_| |_|_|_|_| Reason: .....
2	a) Are you **currently on total or partial sick leave from work**?	◯ YES ◯ NO	Reason: ..... Start date: |_|_| |_|_| |_|_|_|_|
	b) **During the last 10 years**, have you had any periods of **total or partial sick leave from work** lasting more than 15 days?	◯ YES ◯ NO	Reason: ..... Start date: |_|_| |_|_| |_|_|_|_| End date: |_|_| |_|_| |_|_|_|_|
	c) Do you have a recognised **infirmity** or **total or partial disability/incapacity**?	◯ YES ◯ NO	Please specify: ..... Start date: |_|_| |_|_| |_|_|_|_| Origin or cause: ..... Percentage of permanent incapacity or disability: |_|_| %
3	Do you have a **congenital or hereditary disorder**?	◯ YES ◯ NO	Illness: ..... Treatment and/or follow-up: ..... Date of diagnosis: |_|_| |_|_| |_|_|_|_|
4	Have you ever had an **accident** which caused **after-effects**?	◯ YES ◯ NO	Date of accident: |_|_| |_|_| |_|_|_|_| Location of after-effects: ..... Nature of after-effects: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER (CONTINUED) 2

5	a) Are you **currently** having any **medical or paramedical treatment** (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Duration of treatment: .....
	b) **During the last 5 years,** have you had **any medical or paramedical treatment** (medication, physiotherapy, osteopathy, acupuncture, injections, psychotherapy, appliances or laser treatment) lasting more than 15 days?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Duration of treatment: .....
6	During the last 10 years, have you been **admitted** to a **medical facility**, including for periods of less than 24 hours (clinic, hospital, care home, psychiatric unit) for: - an operation or medical or surgical procedure (endoscopy, biopsy, arthroscopy, angioplasty), - specialist examinations and tests, - treatment, - convalescence, - addiction treatment, - rehabilitation, excluding surgery on wisdom teeth, tonsils and adenoids and for appendicitis?	◯ YES ◯ NO	Date: __/__/____ Reason for admission: .... Length of stay: .... Results: .... Prescribed treatment: ....
7	During the last 5 years, have you had any **laboratory tests** (blood, urine or stools), **cardiology tests** (ultrasound, ECG, Doppler, Holter) and/or **medical imaging** (ultrasound, scans, PET scans, scintigraphy, MRI, endoscopy, colonoscopy, gastroscopy, radiology or mammogram)?	◯ YES ◯ NO	Date: __/__/____ Type of test: ..... Reason for test: ..... Results : ..... Prescribed treatment: .....
8	Over the last 12 months, have you had your blood pressure checked by a doctor?	◯ YES ◯ NO	If yes, what were the results? ....
9	**Do you currently suffer or have you suffered over the last 10 years from the following types of illness:**		
	a) **Respiratory** (asthma, chronic bronchitis, tuberculosis, respiratory failure or any other respiratory disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	b) **Cardiovascular** (high blood pressure, phlebitis, heart attack, stroke or any other cardiovascular disorders)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	c) **Ophthalmic/ENT** (glaucoma, cataract, blindness (even if in one eye), deafness or any other eye or ENT disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....
	d) **Articular** (cervicalgia, slipped disc, sciatica, lumbago, polyarthritis or any other disorder of the bones or joints or autoimmune diseases)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: __/__/____ Length of treatment: ..... Results of treatment: .....

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER (CONTINUED) 2

9	**Do you currently suffer or have you suffered over the last 10 years from the following types of illness:**		
	e) **Dermatological** (eczema, psoriasis, lupus or any other dermatological condition)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	f) **Digestive** (Crohn's disease, ulcerative colitis, oesophageal varices, liver disease, pancreatic disease or any other digestive disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	g) **Neuromuscular** (epilepsy, myopathy, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia or any other disorder of the nervous or muscular system)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	h) **Metabolic and endocrine** (thyroid, diabetes, cholesterol, pituitary disease or any other disorder of the metabolic or endocrine system)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	i) **Urinary and renal** (kidney disease, urinary tract disease or any other disorders of the urinary and renal system)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	j) **Genital** (endometriosis, prostate disease or any other gynecological or urogenital disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	k) **Nervous** (depression, stress, anxiety, neuroses, psychoses, fibromyalgia, eating disorders or any other psychological or psychiatric disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	l) **Tumour/Cancer** (leukemia, Hodgkin's disease, lymphoma, benign and/or malignant tumours or any other cancerous disorder)?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
	m) **Other** infectious, viral, parasitic or haematological **diseases**, malaria, hepatitis or disorders requiring medical supervision?	◯ YES ◯ NO	Illness(es): ..... Treatment(s): ..... Start of treatment: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Length of treatment: ..... Results of treatment: .....
10	Have you been screened for hepatitis B and C or the human immunodeficiency virus (HIV), **where the result was positive**?	◯ YES ◯ NO	Virus: ..... Date of test: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ *(you only need to answer YES to this question if the result of one of the tests was positive)*
11	Are you being **monitored by a specialist**?	◯ YES ◯ NO	Reason: ..... Start date of the illness: └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ └ ┘ Treatment(s): .....

8

HEALTH QUESTIONNAIRE FOR MEDICAL EXPENSES COVER (CONTINUED) 2

12	In the last six months, have you had any diagnostic tests (lab tests, medical imaging) **or additional medical examinations**?	◯ YES ◯ NO	Reason: .... Type of examination or tests: ..... Date: __/__/____ Results: .....
13	Is it planned over the next 6 months for you to have **any medical tests** (lab tests, medical imaging, endoscopy or any other medical test), **consult a medical specialist or undergo any medical or surgical treatment**?	◯ YES ◯ NO	Reason: ..... Date of scheduled tests: __/__/____ Nature of scheduled tests: ..... Date of planned treatment: __/__/____ Type of planned treatment: ..... Length of planned treatment: ..... Specialty of the doctor consulted: .....
14	Is it planned within 12 months of the effective date of your insurance policy for you to be **admitted to hospital**, **including as an outpatient** (knee surgery, removal of cyst, childbirth or for any other reason)?	◯ YES ◯ NO	Reason: .... Scheduled date: __/__/____ Length of stay: .....
15	In the last 5 years have you **been accepted for insurance subject to exclusions or additional premiums, or had cover denied or cancelled** by the insurer of a healthcare or death & disability insurance policy (daily sick leave allowance, disability, death)?	◯ YES ◯ NO	Reason for cancellation, additional premium or denial of cover: ....

Details if you answered YES to any of the questions:

8 To help us process your application, you can provide additional details about your health condition.

ADDITIONAL INFORMATION .....

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THE INSURERS' MEDICAL EXAMINERS RESERVE THE RIGHT TO REQUEST FURTHER MEDICAL EXAMINATIONS.

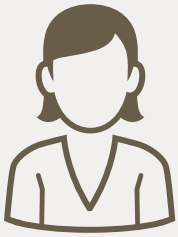
Any non-disclosure, intentional misrepresentation or inaccuracy altering the nature of the risk or influencing the insurers to reduce the risk will result in the cancellation of all cover under the policy. In such circumstances the premium will not be refunded (art. L113-8 of the French Insurance Code).

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.

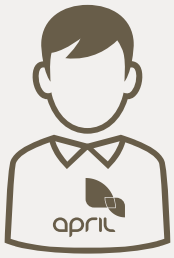
Signed in (town or city) _____ Date d d / m m / y y y y

Signature of the insured preceded by the words **"I have read, understood and accepted the policy document"**:
Signature of the father, mother or legal guardian for insured children under 18:

YOUR APPLICATION STEP BY STEP:



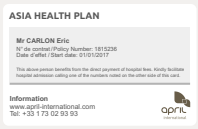
Fill in your Application form and send it to APRIL International Expat.
If you need help, read the tips on the last page or contact us.



Your application is processed on receipt.

You will be sent:

- **your Membership certificate serving as your insurance certificate,**
- **the General conditions showing how your policy operates,**
- **your insurance card containing emergency contact numbers for requesting assistance services or before admission to hospital.**



Please send your completed application to:

APRIL International Expat
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 International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE

CANCELLATION

Article L.112-9 of the French Insurance Code

Any person who is canvassed at their home or residence or place of work, or by means of distance communication 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 letter by recorded delivery 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 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 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 Health Plan Ref. AHP Cov**

Date of signature of Application form: d d / m m / y y y y

Member's surname:

Member's first name:

Member's address:

Postcode: City:

Country:

Telephone: / / / / /

Name of insurance consultant:

Address of insurance consultant:

Postcode: City:

Country:

Telephone: / / / / /

Date and member's signature:

d d / m m / y y y y

Reserved for APRIL International Expat: 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

Card number: ☐☐☐☐ / ☐☐☐☐ / ☐☐☐☐ / ☐☐☐☐ Expiry date: ☐☐ / ☐☐

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 and 3.

B. Select your level of cover 4.

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

D. Calculate your premium and indicate your selected payment method 6.

E. Date and sign your application in part 7.

F. Date, complete and sign the Health questionnaire(s) 8.

G. 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.

H. In order to pay your first premium:
- Provide your credit/debit card details at page 17 of the Application form *OR*
- Arrange for a bank transfer in USD (in this case, attach a copy of the transfer order).

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

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 proof of insurance) showing details of the cover you have selected and the effective 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 international | expat

Headquarters:
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A French simplified joint-stock company (S.A.S.) with capital of €200,000
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)
Autorité de Contrôle Prudentiel et de Résolution (Prudential Supervision and Resolution Authority)
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