

APPLICATION FORM

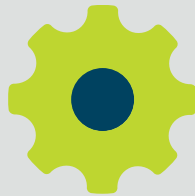
MyHEALTH INTERNATIONAL



**WE ARE DELIGHTED YOU WANT TO BECOME A MEMBER.
THESE ARE THE STEPS TO FOLLOW TO APPLY FOR
MEMBERSHIP OF THE PLAN:**



Complete your Application form and send it to APRIL International Care France by email or post. There are some notes on the next page or you can contact us if you need help with your application.

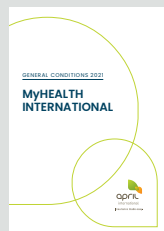


We process your application as soon as it arrives.



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. Check all information in this document.

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

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

D. ● To pay your first premium, you can:

- enclose a cheque made payable to APRIL International Care France, **OR**
- enter your card details on page 12 of the Application form, **OR**
- arrange a bank transfer (in this case, please enclose a copy of the transfer order).

- For future premiums, complete the SEPA direct debit mandate if you want to pay your instalments by direct debit from a bank account in euros (the account must be located within the SEPA zone).
-

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

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

G. If you have taken out additional cover, please also send us the following supporting documents:

- 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 €/€ 80: a copy of your latest tax notice and your most recent payslip.

SEND THESE DOCUMENTS:

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

OR

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

OUR MULTILINGUAL TEAMS ARE AVAILABLE TO ASSIST:



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



by email: info.expats@april-international.com



at our offices: 14 rue Gerty Archimède - 75012 Paris - FRANCE



Surname of 2nd dependent child:

First names of 2nd dependent child:

Date of birth: / / Sex: Male Female

Social Security number/CFE number: Check digit:

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

Surname of 3rd dependent child:

First names of 3rd dependent child:

Date of birth: / / Sex: Male Female

Social Security number/CFE number: Check digit:

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

Surname of 4th dependent child:

First names of 4th dependent child:

Date of birth: / / Sex: Male Female

Social Security number/CFE number: Check digit:

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

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Surname of 5th dependent child:

First names of 5th dependent child:

Date of birth: / / Sex: Male Female

Social Security number/CFE number: Check digit:

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

Surname of 6th dependent child:

First names of 6th dependent child:

Date of birth: / / Sex: Male Female

Social Security number/CFE number: Check digit:

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

Surname of 7th dependent child:

First names of 7th dependent child:

Date of birth: / / Sex: Male Female

Social Security number/CFE number: Check digit:

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



YOUR COVER:

► **CURRENCY:** € or US\$

- **TYPE OF COVER:**
- Cover from the 1st €/US\$
 - Cover as a top-up to the Caisse des Français de l'Étranger (CFE)
 - Cover as a top-up to French Social Security

► **LEVEL OF HEALTHCARE COVER:**

HEALTHCARE BENEFIT	EMERGENCY	BASIC*	ESSENTIAL	COMFORT	PREMIUM
Hospitalisation only	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospitalisation + Outpatient benefits	—	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospitalisation + Outpatient benefits + Optical-Dental care	—	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospitalisation + Outpatient benefits + Maternity	—	—	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospitalisation + Outpatient benefits + Maternity + Optical-Dental care	—	—	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

► **COVERED COUNTRIES:**

Destination country:

Extend cover: Worldwide No extension

Other countries:

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► **DEDUCTIBLE AND LEVEL OF REIMBURSEMENT:**

DEDUCTIBLE	No deductible	500 €/€\$	1.000 €/€\$	2.500 €/€\$	5.000 €/€\$
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OR					
LEVEL OF REIMBURSEMENT	100% of actual costs	90% of actual costs	80% of actual costs		
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

► Annual premium:

COMPREHENSIVE REPATRIATION ASSISTANCE AND PERSONAL LIABILITY (PRIVATE CAPACITY)

► Annual premium:

DEATH AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY LUMP SUM

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

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

► Annual premium:



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

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

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

- My surviving spouse provided we are not legally separated when the lump sum becomes payable, failing which my living, unborn or represented children in equal parts, failing which my ascendants in equal parts, failing which my heirs.
- Other beneficiaries (please specify their **surname, first name, date and place of birth and percentage of the lump sum to be allocated**):

Spouse: I designate as beneficiary in the event of my death:

- My surviving spouse provided we are not legally separated when the lump sum becomes payable, failing which my living, unborn or represented children in equal parts, failing which my ascendants in equal parts, failing which my heirs.
- Other beneficiaries (please specify their **surname, first name, date and place of birth and percentage of the lump sum to be allocated**):

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

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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}: € \$

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

Amount of daily benefit requested:

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

Deferred period: 30 days 60 days

Spouse

Net annual salary^{1,2}: € \$

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

Amount of daily benefit requested:

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

Deferred period: 30 days 60 days

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

► Annual premium:

¹ 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.

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Effective date: / /

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



Calculating and paying the premium

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

► 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:

+

 ,

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

+

 ,

Total* annual premium:

 ,

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

Total amount of 1st premium:

 ,

Your 1st payment is the 1st instalment of the total annual premium.

Pay the 1st premium:

- by cheque made payable to **APRIL International Care France** or by bank transfer.
- by bank card (Eurocard-Mastercard, Visa and American Express).
Please enter your card details in the box on page 12.
- with PayPal (only in case of an online subscription).

Pay future premiums:

- by cheque, bank transfer, bank card or PayPal. For these four payment methods, it is your responsibility to pay the instalments when they are due.
- by SEPA direct debit. Please send us your bank details and complete the SEPA direct debit mandate below.

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

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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 MHCov21IPID and the General conditions (serving as the information notice, reference MHI Cov) and I am aware of my right to cancel the insurance and accept the terms and conditions. I have retained a copy of these. I also understand the terms and conditions of APRIL International Care handling of my insurance cover. My membership is renewed automatically on the plan's anniversary date for a period of one year. If my plan is amended by means of an endorsement, I accept that the General conditions applied will be those referred to above.

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

I understand that cover under this plan does not exempt me from paying contributions to any state benefits scheme to which I may belong.

I accept that the reimbursement of or compensation for expenses incurred as a result of illness, maternity or an accident cannot exceed the amounts which were invoiced to me. I understand that APRIL International Care France requires me to declare any similar insurance cover which I may have purchased from other insurers and that certain benefits are subject to waiting periods.

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

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

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

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

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.



If you decide to waive your insurance, you can use the tear-off slip below and send it to:
 APRIL International Care France - Service Courier - 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 Cov**

Date of signature of Application form: / /

Member's surname:

Member's first name:

Member's address:

Postcode: Town/city:

Country:

Telephone: /

Name of insurance consultant:

Address of insurance consultant:

Postcode: Town/city:

Country:

Telephone: /

Date (DDMMYYYY):
 / /

Member's signature:

Reserved for APRIL International Care France: client reference number





DATA RELATING TO PAYMENTS BY BANK CARD

If you opt for payment by card, in accordance with French Data Protection regulation No. 2013-358 of 14th November 2013, card details are stored only for the purpose of completing your transaction and will be destroyed at the end of the cooling-off period.

Type of card: Eurocard-Mastercard Visa American Express

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

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

Card owner:



april International Care

Headquarters:

14 rue Gerty Archimède - 75012 Paris - FRANCE

Tel.: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90

Email: info.expats@april-international.com - www.april-international.com

A French simplified joint-stock company (S.A.S.) with capital of €200,000

RCS Paris 309 707 727 - Insurance intermediary

Registered with ORIAS under number 07 008 000 (www.orias.fr)

Prudential Supervision and Resolution Authority

4 place de Budapest - CS 92459 - 75436 Paris Cedex 09 - FRANCE

This product is conceived and managed by APRIL International Care France and insured by Groupama Gan Vie (for the medical expenses cover, the death and total and irreversible loss of autonomy cover and the income protection cover) and Chubb European Group SE (for the repatriation assistance cover and the personal liability private capacity cover).

NAF6622Z - VAT registration number: FR60309707727



Insurance made easy.

Surname: First name(s):

Date of birth (DDMMYYYY): / /

VERY IMPORTANT

This Health questionnaire is valid for :

- **3 months** if you are applying for an insurance in the following countries: **Bahamas (Islands), Puerto Rico, the United States, Japan, Singapore,**
- **6 months** for all other countries.

For example, if you want your insurance in the United States to start on 01/04, you can sign the questionnaire between 01/01 and 31/03. Each insured must complete a Health questionnaire. If more than 2 people are to be insured under the plan, please photocopy 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"	<input type="checkbox"/> NO <input type="checkbox"/> YES	Reason: <hr/> Date(s): <hr/> Duration(s): <hr/>
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)?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Reason for hospitalisation: <hr/> Date(s): <hr/> Type of surgery: <hr/> Date(s): <hr/> Is treatment ongoing or scheduled? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES , please provide details:



Surname: First name(s):

Date of birth (DDMMYYYY): / /

3	<p>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, cervicgia, sciatica, or any other spinal disorder) or any other fibromyalgia-type condition?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>Please specify the condition and the prescribed treatment and/or medication:</p> <p>Date(s):</p> <p>Is treatment ongoing or scheduled? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, please provide details:</p>
	<p>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)?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>Please specify the condition and the prescribed treatment and/or medication:</p> <p>Date(s):</p> <p>Is treatment ongoing or scheduled? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, please provide details:</p>
	<p>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?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>Please specify the condition and the prescribed treatment and/or medication:</p> <p>Date(s):</p> <p>Is treatment ongoing or scheduled? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, please provide details:</p>
	<p>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?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>Please specify the condition and the prescribed treatment and/or medication:</p> <p>Date(s):</p> <p>Is treatment ongoing or scheduled? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, please provide details:</p>
4	<p>Have you been screened for any of the human immunodeficiency viruses: HIV and hepatitis B and C, where the result was POSITIVE?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>If YES please provide details:</p> <p>Please provide date(s):</p>



Surname: First name(s):

Date of birth (DDMMYYYY): / /

5	<p>During the last 5 years, have you been prescribed any treatment or medication lasting more than 30 days?</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	Reason(s): Type of treatment: Date(s): Duration(s):
6	<p>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)?</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	If YES: Illness <input type="checkbox"/> Accident <input type="checkbox"/> Type: Date(s): Duration(s): After-effects (if any):
7	<p>Are you currently suffering from any illnesses and/or disorders, or are you receiving any follow-up medical care?</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	Type of illness or disorder: Date/Year of first symptoms: Type of follow-up care: From what date (DDMMYYYY): <input type="text"/> / <input type="text"/> / <input type="text"/>
8	<p>Are you currently being prescribed any treatment or medication lasting more than 30 days or any regular treatment or medication?</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	Reason(s): Type of medical treatment: From what date (DDMMYYYY): <input type="text"/> / <input type="text"/> / <input type="text"/>
9	<p>Do you have a pension, annuity or allowance in respect of incapacity to work or a disability?</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	Details: From what date (DDMMYYYY): <input type="text"/> / <input type="text"/> / <input type="text"/>
10	<p>Do you have any deformities or disabilities?</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	Details: From what date (DDMMYYYY): <input type="text"/> / <input type="text"/> / <input type="text"/>



Surname: First name(s):

Date of birth (DDMMYYYY): / /

IS IT PLANNED <u>OTHER THE NEXT 12 MONTHS</u> FOR YOU TO:		
11	a) have any medical tests (lab tests, medical imaging, endoscopy or any other medical examination)? <input type="checkbox"/> NO <input type="checkbox"/> YES	Reason(s):
		Type of test:
		Date(s):
11	b) have a consultation with a specialist? <input type="checkbox"/> NO <input type="checkbox"/> YES	Reason(s):
		Date(s):
11	c) undergo a surgical operation? <input type="checkbox"/> NO <input type="checkbox"/> 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

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:

