[LA MOBILITÉ]
INDIVIDUALS

Ambassade

Application form 2012

Issued by:

www.siam-consulting.asia

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SIAM CONSULTING

april international

Changing the face of insurance.

Ambassade 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 an e-mail address will allow you to receive information on your reimbursements)

1

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:

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

Address:

Postcode: City:

State/Region/Land/County:

Country:

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

Any correspondence from us (your insurance certificate, general conditions, reimbursement statements etc.) will be sent by e-mail. 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 ◯ Miss ◯ Mr ◯

Surname:

First names:

Address:

Postcode: City:

State/Region/Land/County:

Country:

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

E-mail:

(providing an e-mail address will allow you to receive information on your policy)

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

During your period of insurance you can update your contact details at www.april-international.fr (Individuals).

CHOICE OF BENEFITS AND LEVEL OF COVER

4.1/ Medical expenses cover

Membership: ◯ individual ◯ family (the level of the family premium depends on the age of the eldest person)

Area of cover: ◯ zone 1 ◯ zone 2 ◯ zone 3 ◯ zone 4

Option: ◯ Essentielle ◯ Medium ◯ Extenso

Cover required: ◯ Hospitalisation only ◯ Hospitalisation + Routine healthcare
◯ Hospitalisation + Routine healthcare + Optical-dental care

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Level of reimbursement required*: ◯ 80% of actual costs ◯ 90% of actual costs ◯ 100% of actual costs

* Hospitalisation only cover is only available at 100% reimbursement of actual costs

Annual premium (all taxes included) € . A

For medical expenses, you can be reimbursed by:

◯ cheque in euros.
◯ bank transfer to a bank account in France. In this case, please send us details of your bank account.
◯ bank transfer to an account in the USA. International bank details are required including the IBAN number, SWIFT code, your bank's address, sort code and an ABA routing number.
◯ bank transfer to an account in other countries. International bank details are required including the IBAN number, SWIFT code, your bank's address.

Bank charges will be deducted from any payment over the equivalent of €75. Bank charges are shared for all transfers (of any amount) carried out within the Euro zone.

CHOICE OF BENEFITS AND LEVEL OF COVER (CONTINUED)

4.2/ Repatriation assistance cover

Membership: ◯ individual ◯ family

Area of cover: ◯ European and Mediterranean countries ◯ Worldwide

Annual premium (all taxes included): € ☐☐☐ B

4.3/ Personal liability - private capacity - and legal assistance cover (must be combined with another type of cover under the policy)

• SINGLE PREMIUM PER POLICY

Area of cover: ◯ Worldwide excluding USA/Canada ◯ Worldwide

Annual premium (all taxes included): € ☐☐☐ C

4.4/ Death and total and irreversible loss of autonomy cover

• INDIVIDUAL MEMBERSHIP ONLY

Depending on the level of benefit selected, certain medical formalities may be required. Please refer to page 18 of the brochure.

Principal insured

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

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

Spouse

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

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

Name of beneficiaries

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

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

◯ Other beneficiary: Surname: ..... First names: .....

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

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, my children living, to be born or represented as such; third, equally my ascendants and fourth my other heirs.

◯ Other beneficiary: Surname: ..... First names: .....

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

4.5/ Income protection cover

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

• INDIVIDUAL MEMBERSHIP ONLY

Depending on the level selected, certain medical formalities may be required. Please see page 19 of the brochure.

Principal insured

Gross annual salary*: € ☐☐☐☐☐☐

Corresponding death benefits: € ☐☐☐☐☐☐

Amount of daily benefit requested (between €20 and €200): € ☐☐☐

Deferred period: ◯ 30 days ◯ 60 days

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

Spouse

Gross annual salary*: € ☐☐☐☐☐☐

Corresponding death benefits: € ☐☐☐☐☐☐

Amount of daily benefit requested (between €20 and €200): € ☐☐☐

Deferred period: ◯ 30 days ◯ 60 days

Annual premium (all taxes included): € ☐☐☐☐.☐☐ G

*compulsory fields

5 Choice of effective date: d d / m m /2012 (1st or 16th of the month only)

(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:			
	Direct debit from a French bank account	Credit or debit card*	Bank transfer*	Cheque*
Annually	☐	☐	☐	☐
Twice yearly	☐	☐ €23 per semester or €46 per year	☐ €23 per semester or €46 per year	☐ €23 per semester or €46 per year
Quarterly	☐	☐ €23 per quarter or €92 per year	☐ €23 per quarter or €92 per year	☐ €23 per quarter or €92 per year
Monthly	☐	* If I choose any of these three payment methods it is my responsibility to ensure payment is made for each instalment		

Calculating the annual premium

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

Annual membership fees in addition to cover selected: + € 30.00 I

Annual instalment charges (unless you are paying by direct debit or annually): + € . J

Total premiums* for 12 months: H + I + J : € . K

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

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Total amount of first premium: € .

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 from the effective date of your policy until 31/12/2012. When calculating your premium, remember to take into account the payment frequency selected.

Paying the first premium:

☐ by cheque payable to **APRIL International Expat**, bank transfer or direct debit from a French bank account. In this case, please send us your bank details and fill in the attached direct debit authorisation form.

☐ by credit or debit card (Eurocard-Mastercard and Visa only): ☐ Eurocard-Mastercard ☐ Visa

Card number: / / / Expiry date: m m / y y

The last three digits of the security number printed on the reverse of your card:

Card owner:

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.

☐ by direct debit from a French bank account. Please send us your bank details and fill in the attached direct debit authorisation form.

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

MAKING A DIFFERENCE WITH APRIL International

HANDICAP INTERNATIONAL — FONDATION POUR LA NATURE & L'HOMME

On behalf of our sponsored associations, APRIL International invites you to support the protection of the environment or the improvement of living conditions of disadvantaged populations worldwide.

I would like to make a donation to: ☐ Handicap International ☐ The Foundation for Nature and Mankind

To make my contribution:

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☐ I will make a regular donation of: ☐ €5 ☐ €8 ☐ €12 per year *(to be added to my premium payment each year)*

and/or

☐ I will donate the cents from my healthcare reimbursements *(available to beneficiaries only)*

You can amend or cancel your contribution to the associations by sending an e-mail to suivi.client@aprilmobilite.com.

If you are a French taxpayer, part of your donation is tax-deductible. For Handicap International, you can claim 75% of your donation up to €510 and 66% for higher amounts (capped at 20% of your net taxable income). For the Foundation for Nature and Mankind, you can claim 66% of your donation (capped at 20% of your net taxable income). You will automatically receive a tax receipt for any annual donation over €8.

SIGNATURE OF THE APPLICATION

I hereby apply for membership of the Association des Assurés d'APRIL Mobilité 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.

By choosing personal liability (private capacity) and legal assistance cover, I am applying for insurance with Gan Eurocourtage and Solucia PJ under this policy.

I have read the General conditions Am 2012 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.

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 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 (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.

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.

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

DIRECT DEBIT AUTHORISATION FORM (to be completed if you are paying by direct debit)

I hereby authorise my bank to effect transfers from my account, if adequate funds are available, on the instructions of the organisation named below. In the event of a disputed transaction I have the right to cancel the order by instructing my bank to do so. I will then settle the outstanding amount with the creditor.

Name and address of the creditor: APRIL International Expat - 110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 FRANCE - National Issuer Number 004082

Surname, first names and address of account holder:

Surname of account holder:

First names of account holder:

Address:

Postcode: City:

Country:

Account to be debited:

Sort code: Branch code:

Account number: Transaction code:

Name and address of the bank to be debited:

Name:

Address:

Postcode: City:

Country: FRANCE

Date: d d / m m / y y y y **Signature:**

Please send this form to APRIL International Expat and enclose details of your bank, postal or savings account.

HEALTH QUESTIONNAIRE

Validity of the Health questionnaire: 6 months

Example: if you would like your policy to start on 01/07/2012, you can sign this questionnaire between 01/01/2012 and 30/06/2012

You don't have to fill in the Health questionnaire if only repatriation assistance and personal liability - private capacity - and legal assistance cover have been selected.

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.

9 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 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.

QUESTIONS:	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 illness or an accident which resulted 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 a doctor 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, etc.)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO

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, a handicap or 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, etc.) 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 Is it planned for you to be hospitalised for more than 48 hours for any reason whatsoever **during the 12 months following the effective date of your insurance cover** (removal of tonsils, knee surgery, removal of cyst, childbirth, etc.)?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
12 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, etc.?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
13 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

For new cover from the age of 60, a medical visit at your expense is required and a medical report provided by APRIL International Expat must be completed.

Further details if the response to one of the questions is YES:
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"**:

Signature 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 International Expat Code:

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www.siam-consulting.asia

Siam Consulting Hua Hin Co., Ltd.
Mr. Franck Racine
250/129 Soi 94 Petchkasem Road
77110 Hua Hin Prachuapkhirikhan

Phone: 085.962.2232
eMail: franckracinesiamconsulting@gmail.com

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 OF DOOR-TO-DOOR CONTRACT OF SALE

Article L.112-9 of the French Insurance Code

Any person who is canvassed at their home or residence or place of work, 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 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: **Ambassade Ref. Am 2012**

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

Member's surname:

Member's first name:

Member's address:

Postcode: City:

Country:

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

Name of insurance consultant:

Address of insurance consultant:

Postcode: City:

Country:

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

Date and member's signature:

d d / m m / y y y y

Reserved for APRIL International Expat

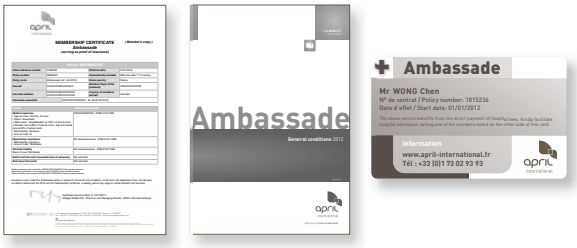
Client reference number C

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 next page or contact us.

Your application is processed within 24 hours.



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.

TAKING OUT THE INSURANCE

A. Fill in your personal details (surname, first name, address, etc.) 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. If you would like to make a donation to one of our sponsored associations, fill in part 7.

F. Date and sign your application in part 8.

G. Date, complete and sign the Health questionnaire 9.

H. - Enclose payment of the first premium by cheque payable to APRIL International Expat, *OR*
- Provide your credit/debit card details on the application form, *OR*
- Arrange for a bank transfer (in this case, attach a copy of the transfer order), *OR*
- Fill in the direct debit authorisation form.

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

Your insurance is evidenced by a Membership certificate (serving as insurance certificate) showing details of the cover you have 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 A MEMBER OF APRIL
Headquarters:
110, avenue de la République - CS 51108 - 75127 Paris Cedex 11 - FRANCE
Tel.: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90
E-mail: info@aprilmobilite.com - www.april-international.fr

Public limited company 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)
Prudential Supervision Authority - 61, rue Taitbout - 75436 Paris Cedex 09 - FRANCE

april international

Changing the face of insurance.