

COMPANY APPLICATION FORM

MyHealth Business

Your company application form, along with the individual enrolment forms (and health questionnaires if applicable), can be sent by email to info.entreprise@april.com

PLEASE WRITE IN CAPITAL LETTERS (*mandatory fields)

SUBSCRIBING COMPANY

Company name*:

Head office address*:

Postcode*:

City*:

Country*:

Main business activity*:

Legal form*:

PLC/CORP.

LC/LLC

ELLP

Other:

Date of creation*:

Business identification number*:

If you wish to take out this insurance for your company and/or on behalf of its subsidiaries, please indicate the name of the corresponding entities and nature of the legal relation:



COMPANY'S CONTACT INFORMATION

Representative of the member company:

Title: Mrs Mr

Last name*:

First name*:

Exact function*:

Phone number*:

+ /

Email*:

Mailing address (if different from head office):

Personel Administration Manager and payment of contribution (if different from the company representative):

Title: Mrs Mr

Last name*:

First name*:

Exact function*:

Phone number*:

+ /

Email*:

Mailing address (if different from head office):

STAFF TO BE COVERED

Occupational category*: Executive Non-executive Other:

Number of employees on international assignment*:

Average age of the company's expatriate population*:

SELECTED BENEFITS AND REQUIRED START DATE*

- Medical expenses
- Repatriation assistance
- Repatriation assistance & civil liability
- Death & disability

Please attach the signed cover proposal with the selected benefits.

Type of intervention: 1st euro 1st US\$

Required start date*:

 / /

The effective date can be no earlier than the 1st of the month following receipt of the completed application.



DECLARATION OF THE MEMBER COMPANY

I hereby apply for membership for my company of the Association des Assurés APRIL and the insurance plan it has purchased from the insurer. I understand that this membership does not exempt me from the contributions payable to the mandatory insurance scheme to which the employees may belong.

I confirm that all personnel belonging to the insured category who meet the conditions are enrolled without exception. If I fail to comply with this obligation I risk the termination of my membership. I agree to inform all employees involved in this membership of their status as insured members and to provide them with the information issued to me by APRIL International Care France on the content and conditions of implementation of the benefits and the processing of their personal data and the rights to which they are entitled.

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

I, the undersigned, confirm that I have answered the questions personally, accurately and honestly and have neither included nor omitted anything which might mislead the Insurer. I have been informed that any non-disclosure or misrepresentation will result in the application of the sanctions set out under articles L113-8 and L113-9 of the French Insurance Code. I confirm that, before entering into the insurance contract, I read and familiarised myself with the Product Information Document MHBCOVID19, the information booklet describing the benefit amounts and the conditions under which they can be claimed, accept its provisions and have kept a copy of it, as well as the conditions applicable to APRIL International Care France's management of the insurance plan. If any amendments are made to my membership by means of an endorsement, I understand that the information booklet is the one I read when I signed the initial membership application form. I also confirm that I have read the extract of the Articles of Association of the Association des Assurés APRIL, which can be viewed in full at the following address "www.association-assures-april.fr" as well as the conditions applicable to APRIL International Care France's management of the insurance plan.

I understand that APRIL International Care France is required to collect personal data which is essential to the processing of the membership application and the enrolment of the relevant employees. This processing is governed by EU data protection Regulation (EU) no. 2016/679 of 27th April 2016. This data processing covers: studying, arranging and managing the insurance plans, the implementation of legal and/or regulatory obligations and the improvement of the products and services marketed by APRIL International Care France. Full information on data processing and the exercise of my rights with regard to this data is provided in the "Information notice - the processing of your personal data" which has been issued to me.

I agree that the information collected on this form may be recorded electronically by the Insurer, the Underwriter or their service providers and partners for the purposes of managing the benefits purchased in accordance with the terms of the Information Booklet. I have the right to access my personal data and have it corrected. I can also for legitimate reasons opt out of it being processed. I can exercise this right by sending a letter to APRIL International Care France - Service Courrier - 1 rue du Mont - CS80010 - 81700 Blan - FRANCE or an email to dpo.AICF@april.com. In accordance with the provisions of Article L561-45 of the French Monetary and Financial Code, persons affected by the monitoring of their data may exercise their right of access by applying to the French Data Protection Authority, Commission Nationale Informatique et Libertés - 3 Place de Fontenoy - TSA 80715 - 75334 Paris Cedex 07 - FRANCE. Complaints relating to the processing of personal data should be made to the French Data Protection Authority, Commission Nationale Informatique et Libertés, on its website www.cnil.fr or by post at the address shown above.

Signed in on / /

Name of signatory:

SIGNATURE OF PERSONEL ADMINISTRATION MANAGER
preceded by the words **"Read and approved"**

SUBSCRIBING COMPANY'S STAMP



TO COMPLETE THE APPLICATION

Please include the following with your application:

- the signed covered proposal with the selected benefits,
- individual enrolment forms signed by your employees or the list of employees to be covered with the relevant information in an Excel file,
- the completed health questionnaires if requested by APRIL International Care.

Send your request to **APRIL International Care** by email to info.entreprise@april.com

We invite you to keep a copy of these documents.

Your insurance consultant stamp
and APRIL International Care code

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APRIL International Care France Head Office:

14 rue Gerty Archimède – 75012 – Paris – FRANCE
Tel: +33 (0)1 73 02 93 93
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
NAF6622Z – VAT N° FR603009707727

