My temporary cover abroad

General Conditions

Ref: MtcCov

(updated July 2021)

april International

INSURANCE MADE EASY

If you have any questions at all about your plan, we would be pleased to advise you and help make everything as straightforward as possible:

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You can also get in touch with our advisors using your portal or Facebook Messenger.

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Please note :
These General conditions apply to the benefits provided by APRIL International Care France. If you opt for joint CFE + APRIL membership, you will be automatically enrolled in the CFE for health and maternity cover in accordance with the French Social Security Code. For information on CFE benefits: www.cfe.fr.

The group insurance plan is purchased by the contracting Association des Assurés APRIL for the benefit of any person who may enrol in the plan who is staying temporarily in a foreign country, anywhere in the world.

These Terms and conditions apply to MyStudies Cover (for the purpose of studies, language training, study internships) and MyTravel Cover (business trips, professional training, or travel or leisure or visits in a professional or private capacity).

1. DEFINITIONS

The language used in insurance can be technical so, to help you better understand how your plan operates, we have provided you with main definitions of the terms used.
Whenever the following terms are written in italics and with a capital letter, they have the following meanings:

1.1 DEFINITION WHICH APPLY TO ALL COVER :

ABROAD: worldwide limited to the countries of cover defined in ARTICLE 2 GEOGRAPHICAL SCOPE and excluding the Insured's country of origin and excluded countries.
ACCIDENT: any bodily injury not intended by the injured person arising from a sudden and unexpected action with an external cause. The cause and the symptoms must be medically and objectively definable, be diagnosed and require care. In application of article 1353 of the French Civil Code, the insured is responsible for providing proof of the accident and of the direct cause-and-effect relationship between it and the costs incurred.
ACTUAL COSTS: all medical expenses charged to *You*.
COUNTRY OF EXPATRIATION: country in which the *Insured* is located during their period of expatriation. It is specified on the *Insurance certificate* as the country of cover. It is different from the *Country of origin*.
COUNTRY OF NATIONALITY: the country shown on your passport or any other official identity document under the heading "nationality".
COUNTRY OF ORIGIN: the *Insured's* country of residence before their expatriation or their *Country of nationality* different from the *country of destination*
DEDUCTIBLE: amount which you will pay towards the settlement of a *Claim*.
DEPENDENT CHILD: your child, or that of your *Spouse*, who is unmarried and dependent for tax purposes up to the age of 21. Children under the age of 28 who are in education, unmarried (even if they are not living with you) are also covered subject to the annual production of proof of continued study.
EFFECTIVE DATE: date on which the membership to the plan starts. It is specified on the *Insurance certificate*.
EXCLUDED COUNTRIES: as a result of events taking place in certain countries, cover in these countries is excluded from the plan. The complete list of excluded countries is available at www.april-international.com, by calling *Us* on +33 (0)1 73 02 93 93 or by sending an email to info.expat@april-international.com. This list of excluded countries is liable to change.
EXCLUSIONS: what is not covered by the insurance plan. All insurance plans have exclusions from cover.
EXPATRIATION: an internationally-mobile person, outside their country of origin is said to be on expatriation.
FORCE MAJEURE: any unforeseeable, overwhelming external event.
F.O.D. (French Overseas Departments): French Guyana, Guadeloupe, Martinique, Mayotte and Reunion Island.
ILLNESS: any deterioration in health, certified by a competent *Medical authority*.
INSURANCE CERTIFICATE: document issued confirming membership of the plan, presenting the conditions of cover and including the *Effective date* of membership of the plan, the full name and date of birth of the member and the insured, the benefits purchased, the type of cover (from the 1st euro or as a top-up to the statutory scheme).
INSURANCE YEAR: period of twelve consecutive months starting on the *Effective date* of the plan.
INSURED "YOU": all individuals who are covered by the benefits enrolled by the *Member*. This means *You* and the members of your family who meet the conditions of insurance. They are listed on the *Insurance certificate*. Family members are your *Spouse* and your *Dependent children*.
LOSS/CLAIM: event, illness or *Accident* giving rise to payment of benefits during the life of the membership to the plan.
MEDICAL AUTHORITY: any person holding a valid medical or surgical diploma who is authorised to practise in their specialist field in the country where *You* are staying.
MEMBER: an individual or legal entity who/which enrols in the open group insurance plan purchased by the contracting association and agrees to comply with the corresponding obligations, including the payment of the *Premiums*. Their contact details are shown on the *Insurance certificate*. The *Member* enrols in the plan either on their own behalf or as the legal representative of an insured person or as the legal representative of the subscribing company.
PREMIUM: sum paid by the member in exchange for cover granted by the insurer.
PRIMARY INSURED, "YOU": individual accepted by the insurer and to whom cover under the plan applies. Their contact details are shown on the *Insurance certificate*.
SPOUSE: husband or wife of the *Primary insured*, from whom they are neither divorced nor legally separated or the *Primary insured's* civil partner (Article 515-1 of the French Civil Code), where the civil partnership is in force on the date of the *Loss*. The *Primary insured's* long-term partner will be classed as a *Spouse* if documentary evidence is provided.
STABILISATION: stabilisation of the state of health of the victim of an *Accident* or person suffering from an *Illness*.
STUDENT EQUIVALENT: apprentices, au pairs or students who are earning during their studies. In all cases, a student's earnings cannot exceed the equivalent of €1,300 per month.
TERMINATION: the early permanent cessation of cover under the plan or the membership.
WE/US: APRIL International Care France.
YEAR (PER YEAR): when "per year" is used in the table of benefits it means "per *Insurance year*".

1.2 DEFINITIONS WHICH APPLY SPECIFICALLY TO MEDICAL EXPENSES :

CLAIMS FORM: form provided on enrolment in the plan to be completed and signed by the prescribing doctor for each claim for reimbursement if the EMERGENCY package has been selected or during a stay outside of the zone of cover. Without this completed and signed document, no claims will be paid.

CONFIDENTIAL MEDICAL CERTIFICATE: medical questionnaire which must be completed by your doctor and returned to *Us* before *You* are admitted to *Hospital* (or as soon as possible following an *Accident* or in case of emergency) in order to obtain our *Prior agreement*. A *Deductible* of 20% will be applied to your reimbursement if *You* do not follow this procedure.
CONVALESCENT CARE, HOME CARE: nursing care received immediately following *Hospitalisation* or day care covered under the plan or to replace *Hospitalisation* which would have been covered under the plan where the care is provided in a *Hospital*, a convalescence centre or the insured person's home. The care is only covered if the treating doctor has taken the decision for medical reasons in agreement with the insurer's medical examiner. Spa therapies, thalassotherapy, fitness centres, palliative care and long-term care are not covered by this benefit.
COMPLICATIONS OF PREGNANCY AND CHILDBIRTH: these are complications that arise during the prenatal period of pregnancy and, in this context, the following are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, risk of miscarriage and stillbirth or hydatidiform mole. The following pathologies are also covered if they appear during childbirth and require an obstetric procedure: postpartum haemorrhage and retained placenta.
DAILY HOSPITAL CHARGE: portion of the cost of a day in *Hospital* in France which is not covered by the statutory French scheme.
DAY HOSPITALISATION ON AN OUTPATIENT BASIS: *Hospitalisation* of less than 24 hours where *You* are allocated a bed but do not stay in hospital overnight and are discharged on the same day.
DENTAL SURGERY: surgical procedure such as the extraction of wisdom teeth performed in a hospital by a dental surgeon or a stomatologist.
DENTURES: crowns, bridges, inlays/onlays, reconstructive appliances or bonded repairs, inlay-cores, dental plates and all required additional treatments. Orthodontic appliances are not classed as dentures.
DIRECT BILLING: payment system whereby the *Insured* is not required to make an advance payment to healthcare service providers. The service providers are paid directly by the Social Security scheme and/or Supplementary healthcare insurers for the medical care or products provided to the patient.
DIRECT PAYMENT OF HOSPITAL CHARGES: *You* may be eligible for direct payment of your hospital charges (*Hospitalisation* of more than 24 hours or *Day hospitalisation*) with no cash advance required if *You* have cover from the 1st € or as a top-up to the CFE, subject to the review of your *Confidential medical certificate*. *You* can activate this service by calling the emergency contact numbers listed in your members' guide or on your EASY CLAIM app. This service is not available if a EHIC or French Security Social top-up cover has been selected.
EMERGENCY DENTAL TREATMENT: dental treatment following an emergency or accident requiring treatment within 48 hours. Emergency dental treatment includes the treatment of:
- Pulpitis (Persistent toothache)
- Dental abscess and/or swelling
- Broken or dislodged tooth
- Dental bleeding
- Alveolitis (inflammation of the tooth socket)
- Acute parodontopathy

Dental check-ups, conservative care such as scaling or the treatment of cavities, and root canal work are not classed as emergency treatments. They do not include dentures, dental implants, periodontics or orthodontics.
HOSPITAL: medical and/or surgical facility duly authorised by the health authorities in the country where it is located. Rest and convalescent homes, spas, thalassotherapy and fitness centres, hospices and facilities for the care of the elderly are not classed as hospitals.
HOSPITAL ROOM: stay in a standard private or semi-private room. Deluxe and executive rooms and suites are not covered.
ILLNESS: any deterioration in health, certified by a competent *Medical authority*.
MATERNITY: non-pathological (*) pregnancy, childbirth and its consequences.
Maternity benefit only applies :
- For *Insureds* under a MyStudies Cover plan, only when the destination is the United States. - For *Insureds* under a MyTraver Cover plan with a Working Holiday Visa, except when the destination is Canada.

The following are covered: all medically required expenses, including the cost of staying in *Hospital*, medical fees, midwife's fees (during labour only), pre- and postnatal care and care of the newborn. Maternity is not classed as an *Illness* or an *Accident*.
(*) Definition of pathological pregnancy: Pregnancy which directly threatens the health of the mother and/or child where an obstetrical or foetal risk is identified during pregnancy and requires specific cover.
MEDICAL AND SURGICAL HOSPITALISATION: stay of more than 24 hours (with or without surgery) in a public or private *Hospital* due to an *Accident* or *Illness*.
MEDICAL AUXILIARIES: paramedical professionals (e.g. nurses, massage therapists-physiotherapists, speech therapists, orthoptists etc.).
MEDICAL AFLICTION: deterioration of the health state or illness.
MEDICAL EQUIPMENT AND APPLIANCES: any medical equipment, appliances or devices which are prescribed as an aid to the function or capacity of the insured person such as artificial limbs, crutches, wheelchairs, orthopaedic supports and hearing aids. Medical equipment prescribed for palliative or long-term care is not covered. This definition does not include dentures, orthodontic appliances or optical appliances.
MEDICAL EMERGENCY: any sudden and unforeseen deterioration in health certified by a competent *Medical authority* and requiring the imperative intervention of a doctor within 48 hours.
NOMENCLATURE: the nomenclatures define the medical treatments and procedures, products and services which are covered by French Social Security and the conditions under which they are reimbursed.
ONCOLOGY: specialty referring to fees, examinations, chemotherapy and radiotherapy treatments and hospital charges incurred in the treatment of cancer.
ORGAN TRANSPLANT: surgical procedure consisting of performing the following (total or partial) tissue or organ transplants: heart, lung, liver, pancreas, kidney, bone marrow, thyroid, parathyroid, bone, muscle or cornea. The benefit does not cover the cost of acquiring the organ.
OUTPATIENT SURGERY: surgery carried out without hospitalisation in a health facility (*Hospital* or clinic), a medical centre or a medical office with the patient arriving and leaving on the same day.
(PRIMARY) OUTPATIENT CARE: all medical care provided by health professionals other than during *Hospitalisation* or stays in healthcare facilities.

These include, for example, consultations in a private medical practice or health centre, clinical laboratory tests, radiology performed in a doctor's office, consultations carried out at a hospital without the patient being admitted (also known as "outpatient consultations") etc.
PALLIATIVE CARE: hospital treatment provided following a diagnosis that the medical condition (illness or accident) is terminal and that no treatment can cure the insured person's condition. Physical and psychological care, the cost of hospital or hospice accommodation, nursing care and prescription drugs are also covered up to the levels shown in the table of benefits. Accommodation and treatment in retirement homes is not covered.
PATHOLOGY: all the manifestations of a disease, the symptoms and morbid effects that it causes.
PATIENT TRANSPORT: the plan covers the cost of transporting the insured person to the closest and most suitable *Hospital* or care facility by ambulance or medical land vehicle. This benefit does not cover the cost of evacuation or repatriation.
POST-NATAL CARE: routine postpartum medical care provided to the mother for up to six weeks after delivery.
PRE-EXISTING CONDITION: Medical condition or pathology which was diagnosed, under medical management, explored through medical testing and/or treated before the signature date of your *Application form* (including the medical questionnaire). Any illness or affliction whether diagnosed or symptomatic which may have been under medical management of which *You* were aware, or of which *You* may have been reasonably aware when enrolling in the present plan is considered a pre-existing condition.
PRE-NATAL CARE: traditional follow-up examinations and screenings required to monitor the pregnancy. This includes, for women aged 35 and over, if medically required, amniocentesis and screenings such as chromosomal abnormalities, tests for spina bifida, Bart's tests and DNA analysis directly related to amniocentesis covered under this plan.
PRIOR AGREEMENT: *Hospitalisation* and medical treatments or procedures costing more than €/$ 2,000 are subject to the *Prior agreement* of our Medical Examiner. Before starting the treatment, *You* will therefore have to send *Us* an itemised estimate of costs and a form called "*Request for prior agreement*". In the event of *Hospitalisation*, please ask your doctor to complete the form called "*Confidential medical certificate*".
PSYCHIATRY: the treatment of nervous or mental disorders by a qualified clinical psychiatrist. These disorders must be associated with real and present distress or a substantial impairment of the insured person's ability to function in a major daily life activity such as their education or their employment. The condition must be clinically severe and meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or the International Classification of Diseases (ICD-10).
REASONABLE AND CUSTOMARY COSTS: medical expenses are considered to be reasonable and customary if they do not exceed the rates normally charged for an identical service or treatment in the location in which they are incurred. Medical costs vary greatly depending on the country, and even between practitioners and facilities in the same area: some charge higher prices than others, but with the same quality of service. To avoid this type of abuse, and using our in-depth knowledge of local health systems, we have been compiling pricing databases for over 20 years. These databases are continually added to and are updated every year.
REQUEST FOR PRIOR AGREEMENT: form to be completed by the doctor in order to obtain the insurer's prior agreement before beginning certain treatments or procedures.
SOCIAL SECURITY SCHEME: none if cover is on a first euro basis or, where applicable, the Caisse des Français à l'Étranger – CFE or any French Social Security scheme for insured members who belong to it.
SYMPTOMS: functional signs, felt or observable, which represents a manifestation of a condition or illness allowing to detect it.
UNFORESEEN (OR SUDDEN) ILLNESS: any deterioration in health certified by a competent *Medical authority*, of a sudden and unpredictable nature.
VISION CARE: consultations and examinations by a qualified optometrist or ophthalmologist, the cost of corrective contact lenses, corrective lenses and frames.
WAITING PERIOD: period during which no *Claims* will be paid. *The Waiting period* begins on the *Effective date* of the membership to the plan, as shown on the *Insurance certificate.*
UNOCAM : Union Nationale des Complémentaires Santé – 12 Boulevard Raspail, 75006 Paris.

1.3 DEFINITIONS WHICH APPLY SPECIFICALLY TO REPATRIATION ASSISTANCE COVER :

ACT OF TERRORISM OR SABOTAGE AND ATTACKS: any clandestine action with an ideological and/or political motive carried out by individuals or groups directed against persons or public or private entities in order to:
- carry out a criminal action intended to harm the lives of others,
- alarm the population and create an atmosphere of general insecurity,
- disrupt public transport or the operation of businesses or institutions manufacturing or processing goods or providing services.

ASSAULT: any bodily injury suffered involuntarily by the *Insured*, resulting from the deliberate, sudden and brutal action of another person or group of persons.
FAMILY MEMBER: your *Spouse*, child, grandparents, brother, sister, father, mother or your legal guardian residing in your *Country of nationality*.
FRIEND: any person designated by *You* or one of your dependants residing in your *Country of nationality*.
MEDICAL TEAM: structure adapted to each individual case and defined by the liaison doctor at Europ Assistance.
STABILISATION: stabilisation of the state of health of the victim of an *Accident* or person suffering from an *Illness*

1.4 DEFINITIONS WHICH APPLY SPECIFICALLY TO *PERSONAL LIABILITY* (PRIVATE CAPACITY) COVER :

BODILY INJURY: damage causing a person physical harm.
CONSEQUENTIAL DAMAGE: all damage other than *Bodily injury* and *Material damage* which is the direct and immediate consequence of insured *Bodily injury* or *Material damage*.
MATERIAL DAMAGE: damage causing harm to the structure or substance of the thing and resulting from an insured event.
PERSONAL LIABILITY: legal obligation of all persons to remedy damage they cause to others.

1.5 DEFINITIONS WHICH APPLY SPECIFICALLY TO BAGGAGE COVER :

BAGGAGE: the *Insured*'s travel bags and suitcases and the personal effects and items contained in them as well as any items which have been checked in with a carrier.
VALUABLES: works of art and collector's items, silverware, watches, jewellery, precious stones and pearls, valuable paintings, furs, video recorders and other photographic equipment and accessories, binoculars, mobile phones and laptop computers and other hi-fi or IT equipment.

1.6 DEFINITIONS WHICH APPLY SPECIFICALLY TO PERSONAL ACCIDENT :

BENEFICIARY: individual person who receives *Compensation* or money from the insurer.
COMPENSATION: sum paid to repair damages or injuries suffered by yourself.
(TOTAL OR PARTIAL) DISABILITY: disability immediately subsequent to an *Accident* making it totally or partially physically impossible (as medically verified and recognised by the insurer) for *You* to carry out the normal exercise of your profession or another profession with conditions equivalent to the one *You* had before stopping work after the *Accident* / to continue with the course in which *You* are enrolled, or your au pair placement.
PERSONAL ACCIDENT: benefit providing the payment of a lump sum if *You* die or become disabled as the result of an *Accident*.

2. BENEFIT AND GEOGRAPHICAL SCOPE OF YOUR PLAN

2.1 WHAT BENEFITS ARE PROVIDED UNDER THE MEMBERSHIP TO THE PLAN??

The policy proposes, for each offer, 2 packages of benefit "Emergency" and "Comfort". Membership to this plan, depending on the package selected, provides you with the following benefits:

With the "Emergency" package:
• reimbursement of medical expenses: *Hospitalisation*, outpatient, optical and dental benefitonly in case of *Medical Emergency* or *Accident*;
• repatriation assistance cover, *Personal liability* (private capacity and internships), baggage and *Personal accident*.
With the "Comfort" package:
• reimbursement of medical expenses: *Hospitalisation* outpatient, in case of *Illness* or *Accident*, dental in case of *Medical Emergency* and *Accident* and optical in case of *Accident*.
• repatriation assistance cover, *Personal liability* (private capacity and internships), baggage and *Personal accident*.

2.2 WHERE ARE YOU COVERED ?

Cover is provided on a year-round basis in the countries of destination listed on your *Insurance certificate*.
Cover also applies in the selected pricing zone
3 zones of cover are available:

Zone 1: Worldwide including the United States.
Zone 2: Worldwide, excluding the United States (including Canada, China, Hong Kong, Mexico, Monaco, United Kingdom, Russia, Singapore and Switzerland).
Zone 3: Worldwide excluding the United States, Canada, China, Hong Kong, Mexico, Monaco, United Kingdom, Russia, Singapore and Switzerland.

Outside the zone of cover, benefits are also provided during one-offs stays, for non-medical reasons, for a maximum duration of 30 cumulative days over the entire coverage period, only in the event of an *Accident* or *Medical Emergency* (and upon presentation of the specific claim form).
Coverage is also provided in your *Country of nationality* if it is included in the selected pricing zone.
If your *Country of nationality* is not included in the selected zone of cover, benefits are provided for one-off stays, for non-medical reasons, for a maximum duration of 90 consecutive days between two stays in your *Country of expatriation*.

As a result of events taking place in certain countries, cover in these countries is excluded from the plan. The complete list of excluded countries is available here at www.april-international.com, by calling *Us* on +33 (0)1 73 02 93 93 or by sending an email to info.expat@april-international.com. This list of excluded countries is liable to change.

If you have opted for EHIC (European Health Insurance Card) top-up cover, the insured must obtain an EHIC before his departure so that coverage is acquired as a top-up to the French social security system for the duration of the main stay abroad in the following countries: Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France (including Guadeloupe, French Guyana, Martinique and Reunion Island), Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal (including the archipelagos of Madeira and the Azores), Romania, Slovakia, Slovenia, Spain (including the Balearic and Canary Islands), Sweden, Switzerland.
Benefits can be claimed in your *Country of nationality* during periods of less than 90 consecutive days between two stays in your *Country of expatriation*, only if your *Country of nationality* is one of the countries listed above.

3. WHO CAN BE COVERED UNDER THE PLAN ?

To be eligible for insurance under the plan or to apply for the renewal of the membership to the plan, *You* must:
- on the *Effective date* of the membership to the plan or on the date of renewal, be under the age of 80,
- on the *Effective date* of the membership to the plan, be 10 years or older in case of individual membership,

- be temporarily *Abroad* (outside your *Country of nationality*) for study, internships, pleasure, business or private visits;
- insure that the *Member* has completed and signed the Application or renewal form, stating the chosen package, zone of cover and type of cover (1st euro or French Social Security top-up),
- have completed and signed the health questionnaire specified in the plan, with a maximum of three months before the requested *Effective date*,
- not be suffering from any incapacity or *Disability* or be undergoing treatment for any *Illness* which is likely to recur or develop,
- not have undergone any recent medical treatment which is subject to relapse, nor be planning to have any treatment in your *Country of destination*.
- for CFE (Caisse des Français de l'Étranger) or French Social Security top-up cover or CAFAT top-up cover, be a member of the CFE and be covered under this scheme for illness/maternity or be covered by French Social Security (or an equivalent French scheme), or by the CAFAT for the duration of the plan,
- If EHIC top-up cover is selected:
  - be covered by the French Social Security scheme,
  - before going abroad, obtain the European Health Insurance Card to be presented to the medical professional in your *Country of destination*.
- If My Studies Cover plan is selected:
  - be students or *Student equivalents* or school pupils, outside your *Country of nationality* for the purpose of travel, studies, language training, au pair placements or professional training.
  - *You* must also be able to produce a copy of your student card or school attendance certificate (or a ²copy of your contract with the host family for au pair placements) which is valid for the entire duration of the stay, if requested to do so by the administration teams at APRIL International,

Special provisions if you are staying in France (including the *French Overseas Departments*) - Universal Health Protection ("Protection Universelle Maladie" or PUMA)
If *You* are living in France on a long-term basis and without interruption for more than 3 months, *You* may be entitled to universal health protection from French Social Security to cover your medical expenses.
If *You* enrol in a plan from APRIL with cover from the first euro, and *You* subsequently meet the conditions for Universal Health Protection, *We* can provide you with cover as a top-up to the French Social Security and make the necessary changes to your plan.
It is *Your* responsibility to check if this applies to you and if you are entitled to Universal Health Protection benefits. More information on the conditions for enrolment is available at: https://www.ameli.fr/assure/droits-demarches/principes/protection-universelle- maladie (in French).

Your family members may also benefit from cover under the membership to the plan (if they are listed on your *Insurance certificate*), provided they comply with the conditions specified above:
- your *Spouse*,
- your *Dependent children*.

Membership is based on the statements made by you and by the *Member* and on the good faith of all parties.
Membership is subject to the medical approval of the insurer. *We* reserve the right to request additional medical formalities based on the responses given in the Health questionnaire. If *You* (or one of your family members) present an aggravated risk (professional or medical), *We* can either accept the application for insurance under special conditions or reject it.

Membership or renewal is evidenced by the issuing of an *Insurance certificate* which includes the effective date of membership, the selected benefits package, the type of cover (from the 1st euro or as a top-up to the Social Security scheme) and the duration of the insurance.
It should be noted that all of the above formalities will be carried out by the *Member* if the *Insured* does not have the legal capacity to enrol (as in the case of minor children).

4. DATE D'EFFET, DURÉE ET RENONCIATION AU CONTRAT

4.1 WHEN DOES THE MEMBERSHIP TO THE PLAN START ?

On the date shown on the *Insurance certificate* and, at the earliest, on the day of receipt of the completed membership application (including the completed and signed Application form and Health questionnaire for all *Insured*), subject to payment of the first *Premium* and subject to our acceptance evidenced by the issuing of the *Insurance certificate* specifying the selected benefits. If *You* have opted for cover as a top-up to the CFE or French Social Security or EHIC or CAFAT, your cover is subject to you being eligible for benefits from your statutory scheme.
If your application requires a medical review, your plan will begin at the earliest on the day following our medical approval.

4.2 *WAITING PERIODS* WHICH APPLY TO THE PLAN:

The cover takes effect for each of the *Insured* on the *Effective date* of the plan subject to the application of the following *Waiting periods*.

For medical expenses cover:
- **10 months for maternity benefit**

In any case, maternity benefit is only covered :
- For *Insured*s under a MyStudies Cover plan, only when the destination is the United States.
- For *Insured*s under a MyTraver Cover plan with a Working Holiday Visa, except when the destination is Canada.

- **15 days if *You* are already abroad when subscribing the plan. This waiting period does not apply in the case of a renewal or in the event of an accident.**

The *Waiting Period* applies from the *Effective date* shown on your *Insurance certificate*. All expenses incurred in respect of treatments or procedures prescribed prior to the *Effective date* of the plan or during the *Waiting periods* are permanently excluded from cover and will not be reimbursed.

4.3 DURATION OF COVER AND RENEWAL OF THE MEMBERSHIP TO THE PLAN

Cover is valid for a maximum of 12 months (extended to 18 or 24 months for insured persons in Canada if required for visa purposes).
The membership to the plan is renewable on request provided *You* meet the conditions of insurance (see paragraph 3). *You* can renew your plan up to three times (up to a maximum period of cover of 36 months(or 48 for Canada)), on request, subject to the agreement of the insurer and once your new Health questionnaire has been reviewed (if required, in case *You* select the COMFORT option and are more than 40 years at the expected date of renewal). This request must be made during the month prior the membership end date shown on the previous *Insurance certificate*.Therefore, this request must be made before the membership end date shown on the previous *Insurance certificate*
It is only possible to change to a new benefits package on the date of application for renewal of membership.

4.4 THE MEMBERSHIP TO THE PLAN COMES TO AN END:

a) if the *Premiums* are not paid (see paragraph 5.4);
b) in the event of termination of the agreement by the insurer or by the "Association des Assurés APRIL" on the annual due date (in this case the Association will inform each *Member*);
c) when *You* no longer meet the conditions of membership set out in paragraph 3;
d) on the day on which you return permanently to your *Country of nationality*;
e) on the last day shown on your *Insurance certificate*;
f) When *You* cease to be enrolled in the CFE or covered by French Social Security (or an equivalent French scheme) or through the EHIC if *You* have CFE or French Social Security or EHIC top-up cover. In this case, *Termination* will take effect one month following receipt of written notification by our Customer Service department.

We will only pay for expenses incurred for treatment and procedures prescribed and performed prior to the date of termination of coverage.

Penalties for false statements:
Whether in respect of statements made on enrolment in the plan or those made during the life of the plan, any intentional concealment or false statements and any omission from or misrepresentation of the risk will, depending on the circumstances, trigger the application of article L.113-8 9 of the French Insurance Code.

In addition, any omission, concealment, false statements, whether intentional or not, in making a *Claim*, failure to declare any other concurrent insurance cover, the submission of inaccurate supporting documentation or the use of any fraudulent means puts the *Insured* and the *Member* at risk of withdrawal of cover and termination of the membership to the plan.

***We* reserve the right to take legal action in order to seek compensation for any damage caused to *Us*. *You* will be required to pay back any benefits paid to you under this plan to which *You* were not entitled.**

4.5 HOW TO CANCEL YOUR PLAN

Signing the Application form does not constitute a binding agreement for the *Member*.

If the Member purchased the insurance as a result of door-to-door canvassing:
The following provisions under article L.112-9-I of the French Insurance Code apply: *"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 registered letter with proof of receipt during a period of 14 calendar days from the date of entering into the agreement without requiring to specify the reasons for the cancellation or being subject to penalties. (...). As soon as they become aware of any circumstances giving rise to a claim under the insurance contract, the policyholder loses this right to cancel".*

If the Member has entered into a distance contract (by telephone or internet):
The *Member* may cancel their membership within 14 days of receipt of the *Insurance certificate*.

In all cases, in order to exercise this right to cancel:
The *Member* must notify *Us* of their decision to cancel their plan by means of a clearly-worded statement within the timescales specified above.

To do this, simply complete the cancellation form available on page 25 or send a letter to APRIL International Care France using the following template:

"I, the undersigned, M..... (first name, last name, address),
wish to cancel my membership of the "MyTempoCover" plan number .....
Signed in (town)..... on.....
Signature "

If the *Member* decides to cancel the plan, they will only be required to pay the *Premium* corresponding to the period during which the risk was covered, with this period being calculated up to the date of termination. *We* will refund the balance to the *Member* no later than thirty days following the date of termination.

However, if the *Member* exercises their right to cancel when a *Claim* has been made under the plan during the cancellation period, the entire *Premium* remains due.

5. PREMIUMS

Membership to this plan does not exempt you from paying contributions to any statutory scheme to which You may belong.

5.1 HOW IS YOUR PREMIUM CALCULATED?

The *Premium* is determined by the selected offer, the status of the *Insured*, the package and option selected, the age group, the zone of cover and the chosen duration of cover. The *Insured's* age used for the calculation of the *Premium* is the *Insured's* age on the *Effective date* of the membership to the plan.
For family memberships, the *Premiums* for each insured are added together to determine the total *Premium*.
Taxes currently payable by the *Member* are included in the *Premium*. Any change in the level of these taxes will be reflected in the amount of the *Premium*.

What to do if your stay is cancelled or modified ?
In case of cancellation, i.e. if *We* are notified in writing before the *Effective* date of the plan :
the Premium will be refunded to the *Member* if the proof of the cancellation of your stay is attached to the request.

In case of termination, i.e. *We* are notified in writing after the *Effective Date* of the plan:
You or the *Member* may terminate the plan after the first 3 months of cover. No refund of premiums for your first 3 months of cover will be made.
If the *Insured* returns home early and permanently, after a period of 3 months of cover, the *Member* must send the insurer a document prooving they have returned home on a permanent basis (receipt for payment of electricity, gas, telephone etc.). The insurer will terminate the plan membership and make a pro rata payment of any remaining *Premium*. If your *Premium* was paid in monthly instalments, *We* will amend the end date of your policy and stop automatic debiting.
Please send *Us* these supporting documents within five days of your return. Otherwise *We* will refund the excess *Premium* corresponding to the period between the date of receipt of your supporting documents and the initial end date of your policy.

5.2 PAYMENT METHODS:

Premiums are payable in advance in euros, according to the payment method chosen by the *Member*:

- in full when enrolling in the plan by payment card or PayPal,
- in monthly instalments by SEPA direct debit taken from an euro account located in the single euro payments area (SEPA) and there is an instalment charge of 3€ per month. This payment method is available only if the duration of the membership to the plan is above 4 months.

The payment of the first premium must be made by card or Paypal when signing the *Application form*.

5.3 WHAT HAPPENS IF THE PREMIUM IS NOT PAID?

If the *Premium* remains unpaid 60 days after its due date, *We* will serve the *Member* with formal notice of suspension of cover. The plan will then be suspended. Following a further period of 10 days, *We* will terminate the plan as of right. *We* may also take legal action to secure the payment of any unpaid *Premiums*.
Once formal notice has been served for non-payment, the *Premium* due for the entire year is immediately payable under the French Insurance Code.
It should be noted that failure to pay the *Premium* and the termination of the plan do not cancel the debt. *We* will take appropriate action to obtain payment of the outstanding *Premium* and will have recourse to a debt recovery firm specialising in international debts. The *Member* is liable for any administration charges incurred as a result of any action taken by us or by our service providers.
If the amount stated in the letter of formal notice is paid after suspension of the plan but before termination, the plan will be revived at noon on the day following payment of the *Premium*.
No expenses incurred during the period of suspension of cover will be reimbursed under the plan, even once the *Premium* has been paid.

5.4 EVOLUTION OF THE PREMIUM :

- **Changes in taxes**: Any tax or contribution of a social or fiscal nature that becomes applicable and whose recovery is not prohibited will be charged to you and payable at the same time as the premium and will increase the amount payable.
- **Regulatory Changes:** We may adjust the *Premium* to take into account any changes in the law or regulations applicable to the Policy. If you do not accept our proposal or expressly refuse the new *Premium*, *We* may terminate the membership 30 days after notification by registered letter.

6. MAKING CHANGES TO THE MEMBERSHIP TO THE PLAN

6.1 HOW TO MAKE CHANGES TO THE MEMBERSHIP TO THE PLAN ?

Before the Effective date of cover: the Member can change the package or the dates of cover initially selected.
Once the Effective date of cover has passed, no further changes can be made to the plan. Once You have enrolled in the plan, no changes can be made to the terms and conditions of your cover: **it will not be possible to add a dependant or change the level of your benefits.**

6.2 WHAT DO YOU NEED TO TELL *US* ABOUT ?

The Insured and the Member must inform Us in writing of any change in status, circumstances or contact details **(otherwise all correspondence sent to the last known address will be deemed to have been served).** We must also be informed of any change of status or occupation.

7. WHAT IS COVERED UNDER THE MEMBERSHIP TO THE PLAN AND HOW TO MAKE A CLAIM

Double insurance:
Reimbursements from the insurer and from any other public or private body cannot be higher than the amount of expenses actually incurred. Double insurance operates within the limits of each type of cover regardless of the date of purchase. Within these limits *You* can claim a reimbursement from the provider of your choice.
***YOU* RISK TERMINATION OF THE PLAN IF YOU DO NOT DECLARE ANY DOUBLE INSURANCE ARRANGEMENTS. THIS OBLIGATION REMAINS IN FORCE DURING THE ENTIRE DURATION OF THE PLAN.**
The limiting of reimbursements to the amount of costs actually incurred is determined by the insurer for each service or treatment covered under the plan.

Your cover includes the following when specified on your *Insurance certificate*.

7.1 MEDICAL EXPENSES:

Medical expenses are covered within the limits of Actual costs and Reasonable and customary costs considering the country in which they were incurred.

7.1.1 TYPE AND AMOUNT OF REIMBURSEMENT

All medical and surgical expenses prescribed or performed by a qualified Medical authority are reimbursed within the limits shown in the table of benefits and on the Insurance certificate. The treatments, care, examinations and consultations must be appropriate and necessary.

In particular, they must:
- be necessary to identify, diagnose or treat the patient's medical condition or injury
- be appropriate to the patient's symptoms, diagnosis or treatment
- comply with medical or scientific knowledge at the time of treatment
- be required for reasons other than the comfort or convenience of the patient or health professional
- have a proven and recognised medical effect
- be considered to be of the most appropriate type and level
- be carried out only for an appropriate length of time
- be carried out in an appropriate place.

In this definition, the term 'appropriate' takes into consideration the health of the patient and the cost of the treatment.

If you have cover as a top-up to the CFE or a French Social Security scheme or to the EHIC or the CAFAT:
Only medical expenses covered by the CFE, French Social Security or by the CAFAT are reimbursed (unless otherwise stipulated in the table of benefits). The amounts shown include the reimbursements from your French statutory scheme (French Social Security or an equivalent French scheme) or the Caisse des Français de l'Étranger or the EHIC. *We* will make a payment in addition to the reimbursement from your statutory insurance scheme.

Expenses are reimbursed item by item based on the package, the benefits and the level of reimbursement selected in accordance with the table of benefits and within the limits of Actual costs. For medical expenses invoiced in a currency other than the euro, the exchange rate applied will be the one in force on the date on which the *Loss* occurred. Only expenses related to treatment received during the period of cover will be reimbursed.
For each offers, there are two medical expenses packages available depending on your needs: EMERGENCY or COMFORT.

EMERGENCY
Medical expenses up to €250,000 Cover in case of *Accident* or *Medical emergency* **only**
Cover up to €750 for expenses related to *Outpatient care* in case of *Accident* or *Medical emergency*
Conditions of cover: for each *Claim*, the *Insured* must ask the prescribing doctor to complete and sign the claims form provided on enrolment in the plan.

COMFORT
Medical expenses up to: €500,000
Cover in case of *Illness*, *Accident* or *Medical emergency*

Cover limits:
The cumulative amount of the reimbursements from the insurer is limited per *Insured* and per *Insurance year* to the amount shown in the table of benefits for each package.
If cover is provided as a top-up to the CFE or a French or European statutory insurance scheme:
Any compensation or benefits of the same type paid by the CFE or French Social Security (or an equivalent French scheme) or any public or private body in France or abroad, will be deducted from the reimbursement paid by the insurer.

Reimbursement amounts:
The reimbursement of costs and medical care listed in the table of benefits below under each package is determined, item by item, by the insurer and within the limits of *Actual costs*.
It should be noted that in the table below, where reimbursements under the plan are in addition to French or European Social Security benefits, the reimbursements expressed as a percentage of actual costs are shown less the benefits paid by this organisation.
Benefits from the insurer are paid, as specified on the *Insurance certificate*, either in addition to reimbursements from the Social Security scheme or from the first euro. However, in the latter case, if the *Insured* and/or their dependants are enrolled in a Social Security scheme, their benefits are paid by the insurer in addition to those provided by this Social Security scheme.
Care received in France or in the declared *Country of origin*, if it is in the cover zone, is reimbursed in the same proportion as in the *Country of expatriation*.
The benefits paid, which may be combined with benefits from the Social Security scheme, are capped in all cases at the level of costs actually incurred by the *Insured*.

BENEFITS	EMERGENCY	COMFORT
Maximum amount of medical expenses per *Insurance year* and per *Insured*	€250 000 Cover only in case of *Accident* or *Medical emergency*	€500 000
MEDICAL AND SURGICAL HOSPITALISATION – Excluding maternity		
› Transport by ambulance (if *Hospitalisation* is covered by APRIL International) › Hospital room and board (including the *Daily charge* in France) › Medical and surgical fees › Examinations, diagnostic tests and drugs › Medical treatments and procedures	100% of *Actual costs* *Prior agreement* required and referral to the most suitable Hospital (depending on the medical condition and the costs charged by the facilities)	
Hospitalisation for the treatment of mental or nervous disorders	80% of *Actual costs*, up to 30 days per year	
Private room	Up to €50 per day	
OUTPATIENT CARE		
Consultations, treatments and procedures carried out by general practitioners or specialists (excluding Psychiatrists)	100% of ***Actual costs*, up to €750 per year only following an *Accident* and *Medical emergency* and on submission of the *Claims* *form***	100% of *Actual costs*
Analyses, laboratory tests, X-rays, prescription pharmacy (excluding contraception, homeopathy, phytotherapy, vaccines, anti-malaria treatment and those prescribed during hospitalisation for use at home, including for chronic illnesses)		
Care provided by nurses and physiotherapists (following a hospital stay covered by APRIL International)		
Psychiatrists	Not covered	80% of *Actual costs* Up to 5 sessions per year
Emergency dental treatment Not resulting from an *Accident*	100% of *Actual costs* Up to €400/year	
DENTAL, PROSTHESES AND OPTICAL RESULTING FROM AN ACCIDENT		
Emergency dental treatment *Dental prostheses* Inlay-Core, Inlay-Onlay Cannot be combined with *Emergency dental treatment* not resulting from an *Accident*	100% of *Actual costs* Up to €800 per year *Prior agreement* required	
▪ Medical or orthopedic prostheses ▪ Hearing aid ▪ *Optical*: prescribed glasses or contact lenses	100% of *Actual costs* Up to €300 per year *Prior agreement* required	

SPECIFIC CASES FOR MATERNITY BENEFIT

Upper limits of the maternity benefits are as follow. This benefit is valid only under conditions listed below :

- For Insured under MyStudies Cover plan when the destination is the United States and covered in zone 1,

BENEFITS	EMERGENCY	COMFORT
MATERNITY – Waiting period : 10 months		
Room and board	Not covered	100% of *Actual costs* up to €7,500/ pregnancy €15,000 in case of a justified C section *Prior agreement* required
Medical fees, treatment and procedures		
Medical diagnostic tests, x-rays, pharmacy		
Standard private hospital room		
Pre and post-natal examinations and care		

- For Working Holiday visas holders, the following maternity benefits are valid as shown below, except when the destination is Canada.

BENEFITS	EMERGENCY	COMFORT
***MATERNITY –Waiting period :* 10 months**		
Room and board	100% of *Actual costs* up to €3,000/ pregnancy €6,000 in case of a justified C section *Prior agreement* required	100% of *Actual costs* up to €7,500/ pregnancy €15,000 in case of a justified C section *Prior agreement* required
Medical fees, treatment and procedures		
Medical diagnostic tests, x-rays, pharmacy		
Standard private hospital room		
Pre and post-natal examinations and care		

In order to claim this benefit, documentary evidence will be requested.

7.1.2 WHAT TO DO IF YOU ARE HOSPITALISED

Hospitalisation* (including maternity) requires *Prior agreemen of our Medical Advisor
To obtain this *Prior agreement*, *You* will need to ask your doctor to complete a form called the "*Confidential medical certificate*" at least 5 days before your admission to *Hospital*.
In the event of emergency *Hospitalisation*, please contact *Us* as soon as possible so that *We* can send you this form.
This form, giving the reason for your admission to *Hospital*, the dates and nature of the condition and the date of the appearance of the first symptoms or the circumstances of the *Accident* (with, in this case, a supporting *Accident* report) should be sent to our Medical Examiner along with any other medical documents which may assist with the assessment of your claim.

If this *Prior agreement* procedure is not followed, a 20% *Deductible* will be applied to the reimbursement of your medical bill (other than in cases of *Accident* or *Medical emergency*).

Provision in respect of the *Direct payment of hospital charges*:
Expenses incurred in connection with stays in hospital and pre-admission examinations may be paid directly by the insurer, subject to their *Prior agreement*, under the usual, reasonable and customary conditions in the country where the *Insured* is staying up to the maximum levels of cover and benefits provided under the plan. Any excess must be paid directly by the *Insured*.

7.1.3 HOW TO REQUEST *PRIOR AGREEMENT* BEFORE CERTAIN PROCEDURES OR TREATMENTS

All medical expenses of €2,000 or more are subject to the *Prior agreement* of our Medical Examiner (valid for 6 months). Before incurring these expenses, *You* will have to ask the practitioner prescribing the treatment to complete a *Request for prior agreement* form together with an itemised quote.
If you are pregnant, please send *Us* a document confirming your condition.

If this *Request for prior agreement* procedure is not followed, a 20% *Deductible* will be applied to the reimbursement of your medical bill (other than in cases of *Accident* or *Medical emergency*).

7.1.4 HOW TO MAKE A CLAIM FOR REIMBURSEMENT UNDER THE PLAN

You must **keep your medical bills (and other supporting documents) for a period of 2 years** from the date on which *You* made the claim. *You* may be asked to produce them when your claim is being processed.

In all cases, please enclose the following documents with your claim:

- the originals of your paid medical bills and fees and dated medical prescriptions. These must show your full name and date of birth, the type of illness, the nature and date of the consultations and the treatment received, together with proof of payment. Prescriptions must clearly show the name and price of the drugs, and indicate the local currency;
- if the treatment requires a *Request for prior agreement*, the *Request for prior agreement* form approved by our medical department;
- for *Hospitalisation*, *You* must also enclose the hospital report and the *Confidential Medical Certificate* completed by your doctor. Please also ensure that your medical bill shows the cost of the private or semi-private room;
- in case of *Accident*, the *Accident* report;
- if *You* have selected the EMERGENCY package, the *Claims form* completed and signed by the prescribing doctor.
- Proof of *Accident* or *Unforseen illness* for treatment outside the coverage area;
- Proof of *Accident* or *Unforseen illness* for dental, orthodontic and optical care;
- Proof of the *Accident* or *Unforseen illness* and the specific claim form completed and signed by the prescribing physician if the EMERGENCY plan is chosen.
- Proof of temporary stay for non-medical reasons of less than 60 or 90 days for treatment in the *Country of nationality*.
- **if *You* have cover as a top-up to a Social Security scheme:** the reimbursement statements (or proof of payment) from the Social Security scheme. The *Insured* must also provide proof of the amount of *Actual costs* if they are not shown on the statement issued by this organisation or if the organisation has not made a payment. It should be noted in particular that for medical care or expenses which are denied or not covered by the Social Security scheme but covered under the plan, the insurer's reimbursement is subject to the presentation of itemised medical bills and additional supporting documents, including the medical prescriptions.

We may request any other supporting documentation *We* deem necessary to check if your treatment is covered under this plan.
Benefits due are payable in Euros. For health expenses invoiced in a currency other than the euro, the exchange rate applied will be that in force on the date of the claim.
If there is a disagreement over the amount of the payment, please let *Us* know within 3 months of the date on which the reimbursement statement was generated.

SPECIFIC CONDITIONS OF COVER FOR HEALTHCARE IN THE USA: OUR HEALTHCARE NETWORK IS AVAILABLE IN ORDER TO PROVIDE YOU WITH A DIRECT BILLING SERVICE.
AETNA and Caremark networks gather 690,000 doctors, more than 5,500 hospitals and more than 68,000 pharmacies in which no cash advance is required, we settle the bill directly for you, whitin the limits of your plan.

HOW TO IDENTIFY THE HOSPITALS, PHARMACIES AND DOCTORS WHO ARE MEMBER OF THE NETWORK?
Nothing could be easier:
> Log on to https://april.globalexcel.com
> Click on the provider you are looking for and then on « Find a provider » ou « Find a pharmacy »
> Choose the location and click on "Search"
> Select "Passport to Healthcare Primary PPO Network" and click on "Continue"
> Select the physicians specialty and choose a health care professional in the proposed list in order to get the contact details
> You can also browse the section "Other useful ressources" for your research or on our EASY CLAIM app.

All healthcare expenses outside of these networks will not be covered, except in case of *Force Majeur*. In certain case of emergency, *You* may not be able to go to a medical practitioner within the AETNA network. In these cases, your healthcare expenses would be covered.

7.2 REPATRIATION ASSISTANCE :

How to benefit from repatriation assistance
It is essential to obtain Prior agreement from the assistance provider to benefit from the following cover.

- by calling +33 (0)1 41 61 23 25,
- or sending a fax to +33 (0)1 44 51 51 15.

The assistance provider only intervenes in a medical capacity after emergency aid has been organised on the orders of a qualified *Medical authority*.
From the first phone call, the *Medical team* contacts the local treating doctor in order to best meet the needs of the sick or injured person.

CONDITIONS OF APPLICATION
The assistance provider only intervenes in a medical capacity after emergency aid has been organised on the orders of a qualified *Medical authority*.
If *You* or the persons accompanying *You* organise any of the assistance services listed below, these costs will only be reimbursed if the assistance provider has been notified of this procedure, given their express agreement and provided you with a case number. In this case, costs will be reimbursed based on supporting documentation and up to the amount that the assistance provider would have incurred if they had organised the service themselves.
The assistance provider will not be held responsible for any delays or failures in the provision of their services in the event of industrial action, riots, popular movements, reprisals, restrictions on the free movement of goods and people, acts of terrorism or sabotage, state of belligerency, civil or foreign war whether war is declared or not, nuclear decay, exposure to ionising radiation and other fortuitous events or in cases of force majeure.

7.2.1 MEDICAL TRANSPORT AND MEDICAL REPATRIATION

In the event of an *Accident* or *Illness*, the assistance provider doctors will contact the local treating doctors and take the decisions best suited to your condition, on the basis of the information gathered and based solely on medical necessity.
If the assistance provider *Medical team* recommends *You* are repatriated, the assistance provider will organise and cover the cost of repatriation, solely on the basis of the medical priorities determined by its *Medical team*.

The repatriation destination may be:

- the most suitable hospital, or
- the hospital nearest your home in your *Country of nationality* (or in your *Country of origin*, if different) or nearest your place of residence in your *Country of destination*, or
- your home in your *Country of nationality* (or in your *Country of origin*, if different) or in your *Country of destination*.

If *You* are hospitalised in a healthcare facility outside the hospital district of your usual place of residence in your *Country of nationality* or your place of residence in your *Country of destination*, the assistance provider will organise your return trip after the medically confirmed *Stabilisation* of your condition and will cover the cost of your transfer to your place of residence in your *Country of destination* or your home in your *Country of nationality*.
Repatriation may be carried out by light sanitary vehicle, ambulance, train, scheduled airline or air ambulance. The *Medical team* is solely responsible for the final choice of the place and date of hospitalisation, your need to be accompanied and any means to be used. Any refusal of the solution proposed by the *Medical team* will result in cancellation of the personal assistance cover. The assistance provider may ask you to use your own travel ticket, if it can be used or changed.

7.2.2 RETURN OF REMAINS AND PROVISION OF COFFIN

In the event of your death, the assistance provider will organise and cover the cost of repatriating your body or ashes from the place of death to the place of burial in your *Country of nationality* (or your *Country of origin*, if different). The assistance provider will cover the cost of post-mortem care, casketing and transportation requirements.
The assistance provider will organise and cover the cost of coffin transport up to a maximum of €1,500.
The funeral, ceremony, local transportation and burial or cremation expenses remain at the expense of your family. The choice of companies involved in the repatriation process rests solely with the assistance provider.

7.2.3 ACCOMPANYING THE DECEASED

If the presence of a *Family member* or *Friend* is essential to identify the body of the deceased *Insured* and complete the repatriation or cremation formalities, the assistance provider will provide a round-trip ticket by air in economy class or by train in 1st class.
This benefit is only available if the *Insured* was alone abroad at the time of their death.

7.2.4 TRANSLATION OF LEGAL AND ADMINISTRATIVE DOCUMENTS

When *You* are *Abroad* or in case of medical repatriation, if *You* have serious difficulty understanding legal or administrative documents in the local language, the assistance provider will arrange and cover the cost of translating these documents into your native language. The assistance provider will provide cover up to a maximum of €500 per *Insurance year*. The assistance provider will not be held responsible for the consequences of poor translations or misunderstandings on your part.

7.2.5 PRESENCE OF A FAMILY MEMBER IF YOU ARE HOSPITALISED FOR MORE THAN 6 DAYS

If your condition does not allow or does not require your repatriation and if *You* are hospitalised locally for more than 6 consecutive days, the assistance provider will provide a *Family member* with a round-trip ticket by air in economy class or by train in 1st class to be with *You*. This benefit is only provided if there is no legally-adult *Family member* with *You*. The assistance company will also arrange and cover the cost of their hotel accommodation (bed and breakfast only) for a maximum of 10 nights at €80 per night. No other temporary accommodation solution will be reimbursed.

7.2.6 EARLY RETURN HOME IN THE EVENT OF THE DEATH OR HOSPITALISATION OF A FAMILY MEMBER

The assistance will provide *You* with a round-trip ticket by air in economy class or by train in 1st class in the event of the death or hospitalisation for more than 5 days of a *Family member* in your *Country of nationality* (or in your *Country of origin* if different). The outward trip must take place within 8 days of the death or hospitalisation.
This benefit can be claimed when the death or hospitalisation occurs after *You* have left to go *Abroad*.
The assistance provider reserves the right, prior to the provision of its services, to request proof of the covered event (hospital report, death certificate etc.).
In order to claim this benefit, *You* must contact the assistance provider to obtain their prior agreement. Otherwise, the assistance provider has the right to deny the reimbursement of any tickets which *You* may have bought Yourself.

7.2.7 EMERGENCY RETURN IN THE EVENT OF DAMAGE TO THE HOME

If *You* are away from home and if your presence there is indispensable to carry out the necessary formalities, the assistance provider will organise your travel and that of any minor children who cannot be cared for locally, to the *Damaged home*. The assistance provider will pay for economy class airline tickets, 1st class train tickets or a category A or B rental car for up to 24 hours, provided that the travel tickets which had been purchased for the return trip cannot be used or changed. This benefit is available within 72 hours of the date of occurrence or date when *You* became aware of the *Loss* and if *You* are more than 50 km away from your home.

7.2.8 EARLY RETURN IN CASE OF AN ATTACK, POLITICAL UNREST OR NATURAL DISASTER

If, on the advice of the local authorities in your *Country of destination*, or those in your *Country of nationality*, due to events rendering the political regime unstable, or due to a natural disaster (such as an earthquake or a flood), *You* are obliged to leave your place of expatriation, *You* may be able to make a claim under the early return benefit.
To make a claim, on your return to your *Country of nationality*, please provide the insurer with all documents enabling *You* to obtain the reimbursement of your travel costs up to the level of the price of an airline ticket (economy class) or train ticket (1st class). This benefit applies only outside your *Country of nationality*.

7.2.9 RETURN OF INSURED FAMILY MEMBERS

If the *Insured* is repatriated for medical reasons or if their body is repatriated, the assistance provider will arrange the return trip home for the *Insured Family members* who were travelling with them. The assistance provider will cover the cost of a one-way ticket by air in economy class or by train in 1st class provided the original means of returning home cannot be used or changed.

7.2.10 RETURN TO YOUR COUNTRY OF DESTINATION AFTER STABILISATION

If following medical repatriation, *You* are able to return to work, the assistance provider, with the agreement of their *Medical team*, will organise your return to your *Country of destination* to allow *You* to continue with your assignment. The assistance provider will cover the cost of a one-way ticket by air in economy class or by train in 1st class.

7.2.11 SENDING URGENT MESSAGES

If it is not practically possible for *You* to send an urgent message and if *You* request it, the assistance provider will send your messages or news to your family members, friends or employer free of charge and by the fastest means.
The messages remain the responsibility of their authors who must be identifiable and their sole concern. The assistance provider acts solely as an intermediary in the transmission of the messages. The assistance provider may also act as an intermediary in the opposite direction.

7.2.12 ENFORCED STAY ABROAD

In the event of an incident classed as *Force majeure* by the public authorities in your *Country of destination* which prevents *You* from returning permanently to your *Country of nationality*, the assistance provider will cover the additional costs incurred as a result of the extended stay, up to a maximum of €80 per night (food and accommodation only) for up to 5 nights.
Cover applies only after the declaration of a state of *Force majeure* by the public authorities of the country where *You* are staying and with the prior agreement of the assistance provider.
All costs incurred without the prior agreement of the assistance provider and costs generated by the extension of a stay that is not due to an event classed as *Force majeure* are not covered under the plan.
In the event of an incident classed as *Force majeure*, all cover under the plan remains in place for a maximum of 5 days from the end date show on your *Insurance certificate*.

7.2.13 TRAVEL ASSISTANCE IF PERSONAL EFFECTS ARE LOST OR STOLEN

When travelling *Abroad*, in the event of the loss or theft of your personal effects (identity documents, means of payment, luggage) or your travel documents, and after the declaration to the competent authorities, the assistance provider will make every effort to assist *You*.
The assistance provider is not authorised to block payments on behalf of third parties. Where replacement documents are made available in your *Country of nationality*, the assistance provider will deliver them by the most rapid means.
The assistance provider can send an advance equal to €1,000 per event in order to allow *You* to make essential purchases.
In the event of the loss or theft of a travel ticket, the assistance provider will advance the cost of a new non-negotiable ticket.
These advances can be made in return for a guarantee provided by either *You* or by a third party. The reimbursement of any advance must be carried out within a period of 30 days starting from the date on which the funds were made available.

7.2.14 SOURCING AND DELIVERY OF MEDICATION NOT AVAILABLE LOCALLY

If essential drugs or their equivalents cannot be obtained locally and were prescribed before departure by your treating doctor in your *Country of nationality* (or in your *Country of origin*, if different), the assistance provider will attempt to source them in France.
If they are available, they will be sent as soon as possible subject to the constraints of local legislation and available means of transport.
This service is available for one-off requests. It does not apply, under any circumstances, to long-term treatments that require regular deliveries or requests for vaccines. *You* are responsible for the cost of the medication. *You* agree to reimburse the amount plus any custom clearance charges within a maximum period of 30 days from the shipment date.

7.2.15 SEARCH AND RESCUE COSTS

The purpose of this benefit is to provide you with the reimbursement of your search and rescue costs incurred by the intervention, in a public or private location, of fully equipped, specialised teams, including the use of a helicopter, to locate *You* and evacuate *You* to the nearest suitable reception centre, up to €5,000 per *Insured* and €15,000 per event.
In all cases, cover is capped at the amount of the costs *You* are required to reimburse in full or in part to the official bodies involved. This cover tops up any other similar cover *You* may have. *You* (or anyone acting on your behalf) must notify the assistance provider immediately verbally, no later than 48 hours after the intervention, stating the reasons for it.

7.2.16 LIMITATIONS ON COVER

If the assistance provider arranges and covers the cost of repatriation or transportation, *You* may be asked to use your own travel ticket.
If the assistance provider has paid for your return trip, *You* must return the unused travel ticket to the assistance provider.

7.3 PSYCHOLOGICAL SUPPORT

In the event of the *Insured*'s Accidental Death or Permanent Disability resulting from an insured *Accident*, or in the event of *Bodily Injury* resulting from an *Act of Terrorism* or *Sabotage* or an *Attack* or *Assault*, the assistance provider will provide psychological support to the *Insured* or the *Spouse* and/or *Dependent children* of the insured person who has died in an accident during the Professional Assignment or trip *Abroad*.
The clinical psychologist will provide the *Insured* or the *Insured*'s *Spouse* and/or *Dependent children* with wholly confidential medical and psychological support to help them deal with the distress suffered as a result of the Event.
The psychologist will help them identify, assess and organise their personal, family, social and medical resources to help them get through this difficult time.
The service is provided by telephone. By simply making a phone call, a suitable appointment is arranged with a psychologist from the assistance provider who will return the call to begin the process. If necessary, the *Insured* may be put through directly to a psychologist if one of the psychologists from the assistance team is available at that time. The consultations are strictly confidential and comply with the codes of ethics in force. The support provided is limited to a maximum of three (3) consultations.

7.4 LEGAL ASSISTANCE

7.4.1 LEGAL FEES *ABROAD*

Following an unintentional infraction of the laws and regulations of your *Country of destination*, and for all non-criminal acts, the assistance provider will intervene, on written request, if legal action is taken against *You*. This benefit does not apply to matters related to your professional activity. The assistance provider will cover the local legal fees up to a maximum of €3,000 per event.

7.4.2 ADVANCE OF BAIL ABROAD

The assistance provider will advance the cost of bail stipulated by the authorities to free *You* or to allow *You* to avoid incarceration during your time *Abroad*.
This advance is made through the intermediary of a local lawyer up to a maximum of €15,000 per event.

You must reimburse this advance to the assistance provider:
- following restitution of bail in the case of nonsuit or acquittal,
- within 15 days of judicial sentencing being passed in the case of conviction,
- in all cases, within 3 months of the date of payment.

7.5 PERSONAL LIABILITY (PRIVATE CAPACITY)

PURPOSE OF THE INSURANCE
The insurer covers the financial consequences of any *Personal liability* that *You* may incur by virtue of the laws and regulations in force in the country where *You* are staying, in a private capacity. Cover applies in the event of *Bodily injury* or *Material damage* which *You* cause to another person resulting in particular from:
- your own actions or those of persons for whom *You* are responsible;
- things or animals owned or kept by *You*;
- any sport or outdoor activity that *You* may practise (except Exclusions listed in paragraph 8);
- liability incurred through participation in internships, with regard to the internship manager, for damage caused to materials used during the internship only;
- renting an apartment,
  - for damage caused to neighbouring apartments,
  - in the event of *Material damage* or *Bodily injury* to your guests.

  This benefit does not in any way replace home insurance and does not exempt *You* from complying with local compulsory insurance requirements.

COVER LIMITS
- *Bodily injury*: €4,500,000 per *Claim*.
- *Material* and *Consequential damage* caused to a third party: €450,000 per *Insurance year*; *Consequential damage* is included for 20% of the insured amount, i.e. €90,000. *Deductible* of €75 per *Claim*.
- *Material damage* caused during internships: €12,000 per *Insurance year*. *Deductible* of €75 per *Claim*.

How to make a claim
As soon as *You* become aware of any circumstances that may give rise to a *Claim* under the plan, *You* must inform the insurer, using the following address France.DeclarationsRC@Chubb.com, **within a period of no more than 15 days**. Details of the circumstances surrounding the *Claim* and their consequences should also be provided

7.6 PERSONAL ACCIDENT

7.6.1 ACCIDENTAL DEATH

The insurer will pay the designated *Beneficiary* or *Beneficiaries* a lump sum of €10,000. It should be noted that, if the *Insured* is under 16 years of age at the time of their death, the amount of the lump sum is in all cases limited to funeral costs.
Cover applies if the *Insured*'s death occurs no more than one year after the *Accident* which caused the fatal wounds or injuries.
However, if the *Insured* dies after having received *Compensation* for permanent *Disability* from the insurer for the same *Accident*, their *Beneficiaries* will receive the death lump sum less the amount of this *Compensation*.

Allocation of benefits
In the event of the *Insured*'s death, the lump sum is paid to the *Beneficiary* (or *Beneficiaries*) designated on the Application form or the ones *You* designated at a later date. *You* may amend the designation if it is no longer appropriate unless the designation has been accepted by the *Beneficiary* in which case it cannot be revoked. The designation of a *Beneficiary* can be carried out by means of a privately witnessed document or by an authenticated deed. If *You* have named a specific *Beneficiary*, *You* can have their contact details included in the policy document. If there is no named *Beneficiary* or if the designation proves to be null and void, the amounts due in the event of death will be paid first to your surviving *Spouse* provided they were not legally separated from *You* when the lump sum became payable or to the co-signatory of a Civil Partnership Contract with *You*; failing which, equally, to your children born, unborn, living or represented; failing which, equally to your ascendants, failing which to your other heirs.
In the event of the *Insured*'s death and if the *Insured* is aged between 16 and 18, the lump sum will be paid to their parents in equal parts or, failing which, to their other heirs.

How to make a claim
The death must be declared by sending the insurer, through the following website **https://www.chubbclaims.com/ace/fr-fr/welcome.aspx**, the supporting documents required for payment, including:
- an extract of the death certificate;
- an extract of the birth certificate;
- a medical certificate stating the date of death and whether the death was natural or accidental;
- any document proving identity and/or marital status;
- any document stating the cause and circumstances of the *Accident* that led to the death;
- an admission certificate issued by the hospital;
- any document that proves that the *Accident* occurred and the direct cause-and-effect link between the *Accident* and the death.

Payment is made to the designated *Beneficiary* within twenty days of receipt of these documents. If there is more than one *Beneficiary*, the lump sum will not be distributed by the insurer but a single payment will be made subject to a receipt being signed jointly by the parties.
When *We* have received notification of the death and been provided with contact details for the *Beneficiary* or *Beneficiaries*, *We* have (15) days to request all the documents required from the *Beneficiary* or *Beneficiaries* in order to process the claim.
On receipt of all the documents making up the claim and if benefits are due, *We* will pay the lump sum within thirty (30) days.
If the payment is not made within this timescale, the outstanding lump sum will generate interest in accordance with current legislation.
If benefits are due, the insured lump sum payable in the event of the *Insured*'s death will be revalued from the date of death, until all of the documents required for payment have been received or, where applicable, until the lump sum has been deposited with the *Caisse des Dépôts et Consignations*, at an interest rate set by law.
If the *Beneficiary* or *Beneficiaries* of the insurance cannot be identified or traced within a period of ten (10) years from notification of the death, the insurer will be obliged to pay the lump sum to the *Caisse des Dépôts et Consignations* (CDC). Sums deposited with the *Caisse des Dépôts et Consignations* (CDC) which are not claimed will be transferred to the State at the end of a period of twenty (20) years from the date on which they were deposited with the *Caisse des Dépôts et Consignations* (CDC).

7.6.2 TOTAL OR PARTIAL PERMANENT *DISABILITY* FOLLOWING AN *ACCIDENT*

In cases of total permanent *Disability* where the degree of Disability is equal to 100%, the insurer will pay you a lump sum **set at €40,000.**
In cases of partial permanent *Disability*, the amount of the lump sum is reduced according to the recognised degree of *Disability*.
The degree of *Disability* is set by the insurer's Medical Examiner once the injuries have stabilised.
• If the degree of partial permanent *Disability* is less than or equal to 20%, no *Compensation* is due.
• If the degree of partial permanent *Disability* is greater than 20%, the amount of *Compensation* will be €40,000, multiplied by the recognised degree of *Disability*.

If *You* had a *Disability* prior to the occurrence of the insured *Accident*, injuries due to this *Disability* are not taken into account. However, if the already infirm limb or organ is affected by other injuries, *Compensation* will be based on the difference between the condition of the limb before and after the *Accident*. If *You* did not follow the treatment *You* were prescribed, *Compensation* will be estimated based on the consequences of the same *Accident* if *You* had followed the required treatment plan.

How to make a claim
You must declare the *Accident* in writing to the insurer, using the following website **https://www.chubbclaims.com/ace/fr-fr/welcome.aspx** within 30 days of the date on which it occurred, excluding fortuitous events or cases of force majeure. The claim must include full details of the seriousness, causes and circumstances of the *Accident*. *You* must also:

- forward any document proving your identity and/or marital status;
- provide a certificate from the doctor called to give first aid, describing the exact nature and current state of your injuries, and their consequences;
- forward all documents required to establish the existence and the seriousness of the *Accident*;
- undergo an examination by the insurer's doctor.

7.7 BAGGAGE AND PERSONAL EFFECTS INSURANCE:

7.7.1 LOSS, THEFT AND DESTRUCTION OF BAGGAGE

This benefit provides cover **of up to €1,600** for all *Baggage*, personal effects and items belonging to *You*, or which *You* have hired, in the event of:
- loss of *Baggage* during carriage by a transport company,
- theft of your *Baggage*, personal effects and items during the outward and homeward journey and for the entire duration of the trip,
- the total or partial destruction of or damage to your *Baggage*, personal effects and items as a result of a catastrophic event such as fire, flood, subsidence or an act of terrorism during the outward and homeward journey and for the entire duration of the trip.

In the event of the loss, theft or destruction of *Baggage* checked in with a carrier, the insurer will intervene only after a proper declaration has been made to the carrier and after deducting the *Compensation* paid by them in respect of their liability.
For *Baggage* and its contents which are lost while in the care of a hotel, the insurer will make a payment less the *Compensation* paid by the hotel where the *Baggage* was left, or its insurer, in respect of its liability.
***Valuables* are covered at up to 50% of the insured value, i.e. a maximum of €800.**
By baggage we mean your travel bags and suitcases and the personal effects and items contained therein. The following are classed as personal items: items with a value greater than or equal to €500 as well as jewellery (fine and cultured pearls, precious stones and hard stones) and furs belonging to you. The following are classed as baggage: laptop computers, electronic organisers, audio-visual equipment, cameras and video or hi-fi devices belonging to *You*.

How to make a claim
You must declare the *Claim* to the insurer, using the following website **https://www.chubbclaims.com/ace/fr-fr/welcome.aspx**, within 5 working days of the loss or damage. After this period, the insurer reserves the right to deny cover.
You will be provided with a list of the supporting documents required.

7.7.2 DELAYED BAGGAGE

If your *Baggage* which has been checked in and placed under the responsibility of the airline company is not delivered to you within 24 hours of your arrival at the scheduled flight's destination, the insurer will provide you with compensation of up to €200 for expenses incurred in the purchase of emergency and essential items.

7.7.3 FRAUDULENT USE OF A SIM CARD BY A THIRD PARTY

The insurer will cover the cost of the fraudulent use of a mobile phone by a Third party if the phone is stolen in an *Assault* during your stay outside your *Country of nationality*, providing the phone was used in this way before the *Insured* made the request to block the SIM card and within forty-eight (48) hours of the date and time of the theft.

7.7.4 SPECIAL PROVISIONS APPLICABLE TO PERSONAL MOBILE PHONES, SMARTPHONES AND TABLETS

The insurer will reimburse the *Insured* up to five hundred euros (€500) per Event for mobile phones, smartphones or tablets which are stolen during an *Assault* or mugging outside your *Country of nationality*, on presentation of supporting documentation.
Depreciation:
• Twenty percent (20%) in the first year (from the first day of purchase)
• Forty percent (40%) in the second year
• No reimbursement after the second year.
In all cases, the *Insured* must provide (initial or replacement) invoices for the purchase of the equipment.

7.8 TRAVEL INCIDENTS

The *Insured* is covered for 'Travel Incidents' if the trip is made on board a scheduled airline operated by an air carrier.
The air carrier must possess the certificates, licenses or authorisations required for scheduled air transport, issued by the competent authorities in the country where the plane is registered.
In accordance with this authorisation, the carrier draws up and publishes routes and fares, for the use of passengers, between designated airports according to regular timetables.
Departure times, connections and destinations are as shown on the travel ticket.
Liability limit: the amount of compensation shown below in respect of 'Travel Incidents' cover is a maximum payable in case of an Event affecting the *Insured* and their accompanying *Spouse* and *Dependent children* at the same time.

7.8.1 DEALAYED DEPARTURE

You are covered for the reimbursement of fees charged by airlines if *You* need to postpone your date of departure for your *Country of destination* or your date of permanent return to your *Country of nationality*.

Cover applies:
- if an exam date is changed to a date which falls during your trip or after the date set for your return to your *Country of nationality*, and this is certified by an official document, provided this was unforeseeable and cannot be postponed, and as long as this exam date was not known on the day this insurance plan was purchased;
- if a re-sit exam is called for a date which coincides with a travel date, as long as this exam date was not known on the day the plane ticket was purchased.

Cover is limited to €100 per *Insured* and per *Insurance year*.

How to make a claim
You must inform the insurer, using the following website **https://www.chubbclaims.com/ace/fr-fr/welcome.aspx**, within 5 working days of the date of the insured event. *You* must include the following information:
your full name and address;
- the exact reason for the postponement of the departure or return date;
- the official document showing the dates of the scheduled and cancelled exams, as well as the new dates on which they will be held;
- the original invoice showing the amount of the airline's change fee.

Any cancellation that does not meet these conditions will not qualify for reimbursement.

7.8.2 FLIGHT DELAYS OR CANCELLATION, OR DENIED BOARDING

If, at any airport whatsoever:
- the *Insured*'s scheduled and confirmed flight is delayed by **four (4)** hours or more from the initial scheduled departure time,
- the *Insured*'s scheduled and confirmed flight is cancelled,
- the *Insured* is denied boarding due to overbooking and no alternative means of transport is available for at least **six (6)** hours,

The *Insured* will be covered up to **Three Hundred euros (€300)** for all expenses related to food, refreshments, hotel accommodation and/or transfers to and from the airport or the terminal.

Cover will not apply in the following cases:
- **Where confirmation is required, the *Insured* had not previously confirmed the flight unless prevented from doing so by industrial action or a case of force majeure,**
- **If the delay was caused by industrial action or a Civil War or Foreign War risk of which the *Insured* was aware before departure,**
- **In the event of the temporary or permanent withdrawal from service of an aircraft on the orders of the civil aviation authorities or the airport authorities or a similar authority in any country.**

7.8.3 MISSED CONNECTION

If the *Insured* misses the departure of a scheduled flight due to the late arrival of the preceding scheduled flight on which they were travelling and no other means of transport is available for at least six (6) hours following arrival at the connecting airport, their expenses related to hotel accommodation, restaurants or refreshments are covered up to Three Hundred euros (€300).
Flight delays or cancellation or denied boarding' cover and 'Missed connection' cover can be combined.

7.9 CURTAILMENT OF TRIP

7.9.1 REIMBURSEMENT OF TRIP EXPENSES

The purpose of this benefit is the reimbursement, on a *pro rata* basis, of trip expenses which have already been paid but not used and non-refundable (excluding travel costs) such as accomodation costs or other services booked and planned during the stay, in the event of an early return home following the *Insured*'s medical repatriation to their *Country of nationality* organised by the assistance provider.
The maximum amount of the daily allowance is €250 per day, with an overall cover limit of €5,000 per *Insurance year*.
The benefit is proportional to the number of unused days of the trip. To calculate the benefit, expenses in respect of administration, visa, insurance, tips and reimbursement or compensation paid by the organiser of the trip or any other organisation to which *You* paid the expenses in question will be deducted.

7.9.2 REIMBURSEMENT OF TUITION FEES

The purpose of this benefit is the reimbursement on a *pro rata* basis of Tuition fees in the event of an early return home following the *Insured*'s medical repatriation to their *Country of nationality* organised by the assistance provider.
The maximum amount of the daily allowance is €250 per day, with an overall cover limit of €5,000 per *Insurance year*.
For the reimbursement of Tuition fees, the calculation will be based on Tuition fees already paid and not refunded for the remaining period of tuition from the day following the event leading to your early return home.

8. WHAT IS NOT COVERED UNDER YOUR PLAN

8.1 EXCLUSIONS WHICH APPLY TO MEDICAL EXPENSES COVER

In addition to the *Exclusions* which apply to all cover listed in paragraph 8.6 below, the following are excluded from the medical expenses cover and their consequences :

- **costs incurred before the *Effective date* of the plan and after it has come to an end;**

- **any expenses incurred for treatment or procedures prescribed prior to the *Effective Date* of the Memebership to the plan or during the *Waiting Period*;**
- **costs deemed to be unnecessary and/or inappropriate by the Insurer's Medical Examiner;**
- ***Pre-existing medical conditions*: any *Illness*, condition or injury, or *Symptoms* related to these, which occurred before the date of enrolment in the plan, of which the *Insured* or their dependants were aware, or could reasonably have been aware;**
- **any medical and surgical expenses which have not been prescribed by a qualified *Medical authority* (qualified and/or which is not recognised in the country where the treatment is provided;**
- **Practitioners, therapists, clinics, hospitals, medical centers not recognized :**
  - **As having special competence for the treatment of the accident or illness concerned) by the authorities in force in the country where the treatment takes place,),**

  Or
  - **As properly qualified, competent or authorized to prescribe treatment by our Medical Director and who have been informed in writing by him/her;**
- **expenses for which a request for *Prior agreement* was not submitted or where it was denied by the insurer;**
- **medical *Hospitalisation* or stays in a sanatorium or preventorium if the facility treating the *Insured* is not approved by the competent public authority;**
- **treatments and costs that could have been incurred by the *Insured* on their return to their Country of nationality;**
- **pre-natal and post-natal care if there is no *Maternity* cover;**
- **all devices, operations and treatments for the purpose of preventing birth: sterilisation, vasectomy and termination of *Pregnancy* (unless there is a threat to the health of the mother, or therapeutic termination), family planning consultations etc.;**
- **any infertility, fertility, contraceptive or foetal surgery, meaning treatment or surgery performed in the uterus before birth, unless it is as a result of complications declared during the Pregnancy;**
- **surrogacy expenses, i.e., any treatment directly related to the use of surrogate mothers (surrogacy), whether the Insured is the surrogate mother or the host parent;**
- **fertility treatments (including medically-assisted procreation);**
- **in case of Hospitalisation, ancillary costs with no direct medical purpose such as telephone, television, internet access, newspapers, taxi fares, meals for visitors etc.;**
- **medical expenses deemed to be excessive, unreasonable or unusual considering the country in which they were incurred. Therefore, only usual and reasonable Costs, meaning reasonable medical expenses generally billed in the country in question for the specific treatment received, and in accordance with standard and generally recognised medical procedures, will be covered and reimbursed under the plan;**
- **supply services that are not essential to the diagnosis or treatment of the Illness or Accident**
- **transportation costs other than by ambulance or land ambulance to the nearest appropriate medical facility if hospitalisation is not covered;**
- **alternative medicine;**
- **care, examinations and treatment of the skin (skin cancer treatment is covered);**
- **for pharmacy items, products that are not recognised as medicines, such as cosmetics, hygiene products, sunscreens and/or moisturisers, make-up, comfort care, vitamins and minerals, food supplements, dietetic products, baby foods and mineral water;**
- **thermometers and tensiometers;**
- **any interventions and/or reimbursements related to medical visits, check-ups, or preventive screening;**
- **cosmetic, aesthetic or reconstructive treatments carried out with the aim of improving or transforming the appearance - even for psychological reasons - unless this treatment is related to restoring the physical appearance or a function following a disfiguring *Accident*, or following surgery related to the Treatment of cancer, during the period of insurance cover;**
- **all health checks and treatments for obesity/anorexia, including, in particular, weight loss or eating disorder programmes or therapies, and medical aids and prescriptions for weight loss/anorexia;**
- **all devices, operations and treatments related to sexual dysfunction (sexual deficiencies, such as impotence, regardless of the cause) or gender-related disorders (disorders related to sex change or gender reassignment);**
- **all types of medical care, treatments, health checks and consultations for mental or psychological illnesses or disorders (excluding stays in psychiatric facilities and consultations with *Psychiatrists*, if covered under the plan and limited to the number of days/sessions specified in the plan) or behavioural disorders (Chapter V of the WHO International Classification of Diseases Version 10). Stays in psychiatric facilities and consultations with *Psychiatrists* are covered under the plan up to the limit of the number of days/sessions specified in the plan;**
- **any psychology or psychotherapy consultations and/or psychoanalysis with a therapist or family counsellor (even if these consultations are with a *Psychiatrist*);**
- **occupational therapy, speech therapy, psychomotor therapy and treatment of psychomotor disorders;**
- **attention deficit disorder with or without hyperactivity ;**
- **harmful, dangerous or addictive use of alcohol, narcotics and/or medication and any treatment arising from the harmful, dangerous or addictive use of these substances;**
- **treatments and stays in treatment centres, fitness centres and convalescent facilities or rest homes, spas, spa resorts and other similar facilities which are not recognised as *Hospitals*;**
- **vaccination costs;**
- **care of the feet by a podiatrist or chiropodist, such as: the treatment of corns/calluses or thickened and/or deformed nails, except in cases of medical necessity and approved by the APRIL International Care France Medical Examiner;**
- **surgery or extraction of wisdom teeth;**
- **any non-emergency dental care such as: routine dental examinations, scaling, cavities/cavities, reconstructive care, crowns and/or crown repairs, or any other treatment not required for pain relief;**
- **laser eye surgery (including myopia correction) and cataract treatment;**
- **research and transportation costs for organ transplants;**
- **hospitals and facilities for non-independent elderly, retirement facilities and long-stay hospitalisations;**
- **care provided in a nursing home or retirement home, and the cost of assisting a person in their day-to-day**

activities, even if that person has been declared as having a temporary or permanent disability. This type of service is classed as home care even if it is prescribed by a doctor and delivered by providers with medical or paramedical status;
- travel and hotel accommodation in connection with medical care;
- non-prescribed drugs and non generic drugs when a generic equivalent exists;
- expenses deemed unnecessary and/or inappropriate by the insurer's Medical Officer;
- the cost of Hospitalisation in a deluxe room, VIP room and other suites;experimental treatments or medication, meaning any form of treatment or medication which is not in established usage or whose effectiveness has not been proven;
- any charges caused directly or indirectly by an error on the part of the medical provider;
- all evacuation costs;
- sleep disorders, including insomnia, unless the insured is declared to have severe sleep apnea;
- psychomotor therapy;
- preventive treatments;
- any scheduled Hospitalization, at the time of enrolment, within 12 months of the start of the contract, for any reason whatsoever;
- doctor's fees charged for purely administrative services (for example, obtaining a visa, completing a claims form etc.);
- non-medical hospital admissions or hospital stays which involve:
  - treatment which could have taken place on a day or outpatient basis,
  - treatment which is not medically justified in the opinion of the APRIL International Care France Medical Examiner,
  - convalescence.

As well as the consequences:
- radioactivity or any nuclear material, explosions or *Illnesses* which have been declared an epidemic (except Covid-19) and placed under the control of the public health authorities and any other conflict or disaster, if the *Insured* has endangered themselves by entering a conflict zone recognised by the Government of their *Country of nationality*, has actively taken part in the conflict or has shown a blatant disregard for their own safety;

In addition, by way of reminder, the Maternity benefits shown in the table of benefits can be claimed only in the United States, to the exclusion of all other countries, and only to *Insureds* who have enrolled in MyStudies Cover or who are expatriating under a Working Holiday Program, except for Canada.

If you choose to have coverage in addition to a basic scheme plan, any medical and surgical expenses not prescribed by a qualified medical authority and not covered by the French Social Security system are also excluded (unless otherwise specified in the Table of Benefits).

8.2 EXCLUSIONS WHICH APPLY TO REPATRIATION ASSISTANCE COVER:

In addition to the *Exclusions* which apply to all cover as listed in paragraph 8.6 below, costs resulting from the following facts or events are not covered by the repatriation assistance benefits and will not give rise to any compensation whatsoever nor to any intervention on the part of the assistance provider:

- any interventions and/or reimbursements related to medical visits, check-ups, or preventive screening;
- benign conditions or injuries which can be treated locally and do not prevent the Insured from continuing their journey;
- convalescence, conditions in the process of being treated and not yet stabilised and/or requiring further planned treatment;
- Pre-existing conditions which had been identified prior to departure and which were at risk of aggravation or relapse;
- conditions requiring hospitalisation in the 6 months prior to departure;
- any consequences of a condition which required repatriation (check-ups, further treatment, recurrences);
- pregnancy, childbirth and post-natal care of newborns, and elective termination of pregnancy;
- the consumption of alcohol and the consequences thereof under local legislation;
- travel undertaken for diagnosis and/or treatment;
- the consequences of the failure of, unfeasibility of, or reaction to any vaccination or treatment required or mandatory for travel;
- congenital Illnesses or deformities;
- the consequences of deliberate non-compliance with the regulations of the country being visited or the practice of activities which are not authorised by the local authorities;
- the consequences of participating in a bet, challenge, duel or crime;
- the consequences of non-compliance with recognised safety rules for the practice of sporting activities;
- living expenses other than those for which prior agreement has been obtained from the assistance service;
- the cost of fuel, toll charges and ferry crossings;
- costs which are not supported by original documents;
- any other costs not provided for under the insurance which has been purchased.

<u>The following are not covered:</u>
- medical expenses;
- cures, stays in rest homes and rehabilitation;
- contraception and fertility treatment;
- glasses and contact lenses;
- cosmetic prostheses, dentures and hearing aids;
- regular transportation required as a result of the *Insured*'s health.

The following are not covered under the Enforced stay abroad cover:

- costs incurred without the prior agreement of the assistance provider;
- costs incurred as the result of an extension of the stay which was not due to a *Force majeure* event as defined in paragraph 1 and confirmed by the competent public authorities.

The following are not covered under the search and rescue cover:

- search and rescue costs resulting from a failure to observe the rules of caution laid down by the site operators and/or the regulatory provisions governing the activity being practised by the *Insured*;
- search and rescue costs resulting from the practice of a professional sport or participation in an expedition or competition, unless otherwise expressly stipulated.

8.3 EXCLUSIONS WHICH APPLY TO THE BAGGAGE AND PERSONAL EFFECTS INSURANCE:

In addition to the *Exclusions* which apply to all cover listed in paragraph 8.6 below, the following are excluded from this cover:

- cash, personal papers, business documents, administrative documents, traveller's cheques, credit cards, airline tickets, travel tickets and vouchers;
- smoking-related *Accidents* and damage to items that fall or are thrown into a fireplace, or scorched by excess heat;
- damage to electrical devices due solely to their operation, and damage caused by an inherent defect of the item;
- damage to insured property resulting from its confiscation or detention by customs officials or other public authorities;
- breakage or damage to delicate or fragile items such as watches, photographic equipment, glasses and IT equipment;
- normal wear and tear;
- theft committed by members of the *Insured*'s family, under Article 380 of the French Penal Code, or with their complicity, or by their domestic workers or agents in the course of their duties;
- theft committed under the following circumstances:
  a) in the case of checked baggage, if the theft was facilitated by poor or defective packaging;
  b) if the items were left unattended in a public place or in a place open to use by several occupants;
  c) if the items were left:
  - in a convertible vehicle;
  - in a vehicle whose windows were not closed;
  - in a vehicle whose doors or boot were not locked;
  - between 10 p.m. and 7 a.m. in a motorised vehicle not parked in a public or private garage, except for items in the hold or boot of a bus or coach;
- theft committed in your place of residence without breaking and entering which is duly reported to an authority (police, gendarmerie, transport company, purser etc.).

8.4 EXCLUSIONS WHICH APPLY TO THE PERSONAL LIABILITY (PRIVATE CAPACITY) COVER:

In addition to the *Exclusions* common to all cover listed in paragraph 8.6 below, the following are excluded from cover:

- damage resulting from any professional activity (except for damage to materials used during in-company internships);
- the financial consequences of contractual liability which the *Insured* incurred beyond any liability incurred with regard to the internship manager for damage caused to materials used during the internship;
- the road traffic risks defined under French Acts 58208 (27 February 1958) and 85.677 (5 July 1985) on mandatory motor vehicle insurance;
- *Accidents* involving the *Insured* or their employees or agents in the course of their duties as well as their ascendants and descendants;
- damage caused to items or animals owned or kept by the *Insured*;
- related fines and costs for which the *Insured* may be liable;
- damage resulting from the *Insured*'s use of any air navigation devices;
- damage resulting from pollution;
- scratches, chips and abrasions to sanitary fixtures, breakage of crockery and damage to bedding.

8.5 EXCLUSIONS WHICH APPLY TO ALL COVER:

In addition to the *Exclusions* listed for each benefit, all costs and consequences are excluded from cover in relation to:

- intentional acts by the *Member* or the *Insured* and/or infractions of the law of the country where the *Insured* is staying;
- civil or foreign wars, riots, insurrections, industrial action, piracy or sabotage, voluntary participation in fights or popular movements, acts of terrorism regardless of location and protagonists (except in the case of self-defence);
- voluntary participation by the *Member* or the *Insured* in acts of terrorism, regardless of the location of the events;
- suicide or suicide attempts in the first year of cover;
- the use of drugs or narcotics without a medical prescription;
- alcoholism or drunkenness on the part of the *Insured* (alcohol level higher than that defined by the road traffic law applicable on the day of the *Loss* in the country where it took place);
- road traffic *Accidents* involving two-wheeled vehicles if the *Insured* was not wearing a helmet;
- the direct or indirect effects of changing the structure of the atomic nucleus, climatic events such as storms and hurricanes, earthquakes, floods, tidal waves and other disasters unless these are covered under compensation for natural disasters;
- *Accidents* or *Pre-existing conditions* before the *Effective date* of the plan which are subject to relapses or not stabilised, and congenital illnesses or deformities;

- **carrying out any professional activity on an oil rig.**

Specific conditions for the cover of sports and sporting activities

In addition to the *Exclusions* listed for each benefit, all costs and consequences are excluded from cover in relation to:
- **participation in any sporting competitions and training for these competitions as well as the practice of any sports in a club or federation;**
- **the practice of the sports listed below:**
  - **extreme sports: bungee jumping, caving, extreme canoeing and kayaking (in rapids greater than Class V, rivers greater than Class II, on seas and oceans more than two nautical miles from land), sailing (transoceanic and single-handed navigation more than 20 nautical miles from shelter) and base jumping,**
  - **mountain sports: mountaineering, climbing (excluding artificial holds without a safety rope), rock climbing, hiking above 3,000 metres, ski jumping or snowboarding, bobsleigh, skeleton, skiing (alpine, cross-country and snowboarding) off marked trails which are open to the public, and canyoning,**
  - **air sports: aerobatics, gliding, parachuting, microlighting, hang gliding, paragliding and skysurfing,**
  - **water sports: scuba diving as part of a sporting competition or for leisure purposes, riverboarding and kite surfing in a sporting competition or for leisure purposes, sailing or cruising on the high seas in a private or professional capacity (more than 200 nautical miles from land).**
  - **competitive self-defence and combat sports,**
  - **motor sports: motor racing, motorcycle racing or kart racing;**
- **the practice of sports in a professional capacity. This exclusion does not apply to teachers and coaches. However, their participation in a sports competition will not be covered. The exclusion on extreme sports also applies;**
- **participation in sports courses and study programmes;**
- **the practice of any sport requiring the use of any land, air or sea engine;**
- **the practice of sporting activities involving the use or presence of an animal such as horse riding, equestrian competitions and bullfighting;**
- **air navigation *Accidents* unless the Insured is simply a passenger on board an aircraft for which the owner and the pilot have all the required permits and licenses;**
  However, the practice of these sports, including introductions to the sport, for leisure purposes or by way of "initiation", if it is supervised by a professional with the qualifications and skills required by the State, is covered with the exception of 'extreme' sports.

9. GENERAL PROVISIONS

9.1 WHO INSURES YOUR MEMBERSHIP TO THE PLAN ?

An agreement was entered into by the "Association des Assurés APRIL" (regulated by the Associations Act of 1901, located at 114, boulevard Vivier Merle, 69439 Lyon Cedex 3, FRANCE, whose purpose is to study, effect and promote, to the benefit of its members, all types of insurance, encourage a spirit of international solidarity between them, make available to them all appropriate means of information and administration and ensure their representation with respect to all insurance companies. The statutes of the Association can be downloaded from http://assoexpat-a3i.fr/association):

for medical expenses cover:
in respect of optional group insurance plans, with Groupama Gan Vie (medical expenses plan numbers 219/636815, 219/636816, 219/636817, 219/636818) a French public limited company with capital of €413,036,043 (fully paid) – Registered in Paris under number 340 427 616 – (APE code 6511 Z) located at 8-10, rue d'Astorg – 75383 Paris Cedex 08 FRANCE;

for repatriation assistance, personal liability (private capacity), personal accident, baggage insurance, travel incidents and curtailment of trip cover:
in respect of an optional group insurance plan, with Chubb European Group SE (plan numbers FRBOTA40912, FRBOTA41180), a company regulated by the French Insurance Code with share capital of €896,176,662. Head office: La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, FRANCE. Registered in Nanterre under number 450 327 374 (APE Code: 660E).
Enforcement of the economic and social sanctions:
If the benefit or the payment of the indemnity or the loss provided by these policy violates the resolutions of the United Nations or the sanctions, laws or commercial and trade rules of the European Union, the United Kingdom, a national legislation or the United States of America, such a benefit or such an indemnity or loss payment are null and void

9.2 LEGAL

The body responsible for regulating insurance activities is: Autorité de Contrôle Prudentiel et de Résolution (Prudential Supervision and Resolution Authority) located at 4 place de Budapest, 75436 Paris Cedex 09, FRANCE;
APRIL International Care France is regulated by the Autorité de Contrôle Prudentiel et de Résolution (Prudential Supervision and Resolution Authority), located at 4 place de Budapest, 75436 Paris Cedex 09, FRANCE.

Membership of the MyStudies Cover or MyTravel Cover plan consists of the Application form, these General conditions and the *Insurance certificate*. It is subject to French legislation and in particular to the French Insurance Code.
The benefits and levels of reimbursement provided under this plan will be automatically adjusted in accordance with amendments to the legislation and regulations governing insurance plans under French Law.

9.3 LIMITATION PERIOD:

Under the provisions of article L.114-1 of the French Insurance Code, any legal action arising from an insurance plan is inadmissible after a period of two years from the event which gave rise to it. However, this time limit runs:
1. In the event of non-disclosure, omission or false or inaccurate statements in respect of the risk incurred, only from the day on which the insurer became aware of it;
2. In the event of an insured loss, only from the day on which the relevant parties became aware of it, if they can prove they were unaware of it until then.

If the action taken by the insured or the policyholder against the insurer arises from a claim made by a third party, the limitation period runs only from the day on which this third party brings a legal action against the insured or the policyholder or has received compensation from them.

Under the provisions of article L.114-2 of the French Insurance Code, the limitation period is interrupted by one of the ordinary causes of interruption of the limitation period. The limitation period is also interrupted by:
- the appointment of experts following a claim;
- the dispatch of a registered letter with proof of delivery from the insurer to the policyholder regarding action for payment of the premium and by the policyholder to the insurer regarding the payment of benefits.

The ordinary causes of interruption of the limitation period are listed under articles 2240 onwards of the French Civil Code. They are:
- the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the limitation period (Article 2240 of the French Civil Code);
a legal claim, including summary proceedings, until the end of the hearing. This also applies when the legal claim is brought before a court which has no jurisdiction or where the act of referral to the court is cancelled by the effect of a procedural irregularity (Articles 2241 and 2242 of the French Civil Code). The interruption is void if the claimant withdraws their application or allows the suit to lapse, or if they are defeated in their claim (Article 2243 of the French Civil Code);
- an act of enforcement or interim measures taken in implementation of the code of civil enforcement procedures (Article 2244 of the French Civil Code);
- a summons served on one of the joint debtors by means of legal action or an act of enforcement or the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the limitation period interrupts the limitation period against all the others, even against their heirs (Article 2245 of the French Civil Code);
- A summons served on the principal debtor, or their acknowledgement, interrupts the limitation period against the surety (Article 2246 of the French Civil Code).

Notwithstanding article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by mutual agreement, modify the duration of the limitation period, nor add to the motives for its suspension or interruption.

9.4 SUBROGATION:

It is stipulated that the insurer does not waive the rights and actions that they possess by virtue of Article L.121-12 of the French Insurance Code relating to the summary remedy it may seek for third party liability.

If *You* are involved in a road traffic *Accident* (involving a motorised vehicle), *You* must provide the insurance provider of the person having caused the *Accident*, when requested, with the name of your third party healthcare provider. Failure to do so may invalidate your insurance cover.

9.5 AUDIT:

The insurer may request any other supporting documents they deem necessary. Any supporting documents of a medical nature should be sent to the insurer's medical examiner under confidential cover.
If there is a disagreement over the amount of the payment, the *Insured* must notify the insurer within 3 months of the date on which the statement was generated.
The insurer may also carry out audits or medical assessments carried out by an independent health professional chosen by the insurer, who will pay for this service. During these audits or assessments, the insured may be assisted, at their own expense, by the health professional of their choice or present the conclusions of their own practitioner.
If the insured refuses to provide the requested supporting documents or undergo the medical assessment requested by the insurer, the insurer may deny cover and the reimbursement of the costs in question.
An insured person who intentionally supplies false information or uses forged or altered documents when making a claim will lose all entitlement to cover for the claim in question.
If there is a disagreement over the conclusions of the expert assessment, the insured must send the insurer's medical examiner, within 30 days of notification, in a confidential envelope, a registered letter with proof of receipt stating the subject of the disagreement and enclosing the medical information forming the basis of the argument. If the disagreement persists, an arbitration process will be initiated including, in addition to these two doctors, a third doctor appointed by them. Each party pays the fees of their own doctor with those of the third doctor and the costs involved in their appointment being paid equally by both parties.

9.6 COMPLAINTS - MEDIATION:

Quality of service is at the heart of our commitments, but if *You* do wish to make a complaint about the services provided by our company, *You* can do so through your usual contact.
If *You* are not satisfied with the response provided, *You* can contact our Customer Service department at:
APRIL International Care France - Service Courrier - 1 rue du Mont - CS 80010 - 81700 Blan - FRANCE Email: reclamation @ april-international.com

For your information, our insurance partners Groupama Gan Vie (8-10, rue d'Astorg, 75383 Paris Cedex 08, FRANCE) and Chubb European Group SE, (La Tour Carpe Diem, 31, place des Corolles, Esplanade Nord, 92400 Courbevoie, FRANCE) have entrusted us with the handling of complaints.
We will do our utmost to respond to your complaint within a maximum period of 48 working hours and are committed to keeping you
informed of the progress of your complaint within the same timescale if, for reasons beyond our control, it needs to be extended.
If the dispute persists and if no amicable solution can be found, *You* may, without prejudice to other legal remedies available to you, contact the French Insurance Ombudsman, - "La Médiation de l'Assurance" - TSA 50110 - 75441 Paris Cedex 09 – FRANCE.
If *You* enrolled in this plan remotely via the Internet, *You* can also apply to the relevant ombudsman by lodging a complaint on the European Commission's dispute resolution website at the following address: http: //ec.europa.eu/consumers/odr/.
We would inform you that the data collected in order to handle your complaint will be processed electronically by our company for the purposes of complaint monitoring and will be passed on for this purpose only to the insurer, their reinsurers and the APRIL holding company as well as to our partner service providers for the implementation of your insurance cover. The information collected is essential for the registration, administration and activation of membership applications by APRIL International Care, the insurers or their agents. *You* have the right to access your personal information and have this information corrected or deleted. *You* can also withdraw your consent to this data being processed (see paragraph 9.7).

9.7 DATA PROTECTION AND FREEDOM OF INFORMATION:

In the course of our relationship, *We* are required to collect personal data about you. Information on how the data is processed and how *You* can exercise your rights in respect of this data can be found in the Data Protection Notice provided to *You*. This document is also available from our advisors and on our website at www.april-international.com.

If you want to cancel your membership of the plan, you can use the tear-off slip below and send it to APRIL International Care France - Service Courrier (Mail service)- 1 rue du Mont - CS 80010 - 81700 Blan - 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 communications 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 registered letter 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, please fill in and sign this tear-off slip. You should then send it in an envelope by registered letter with proof of receipt to the above address. It must be sent no later than 14 days from the day following the day of signature of your Application or, where the deadline expires on a Saturday, Sunday or a public holiday or other non-working day, on the next working day.

I, the undersigned, wish to cancel my Application for insurance under the following plan :

Plan name : **MyStudies Cover / MyTravel Cover Ref. Mtc Cov**

Date of signature of the Application form : .....

Member's last name : .....

Member's fist name : .....

Member's address : .....

Postcode : ..... City : .....

Country : .....

Telephone number: .....

Name of insurance consultant : .....

Address of insurance consultant : .....

Postcode : ..... City : .....

Country : .....

Telephone number: .....

Date and member's signature :

Reserved for APRIL International : client reference number C_ _ _ _ _ _ _ _ _

APRIL International Care France Head Office:

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.expat@april-international.com - www.april-international.com

SA 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

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STATUTES

ASSOCIATION DES ASSURES APRIL

Updated 17th April 2018

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Association des Assurés APRIL
Association governed by the French Act of 1st July 1901 and the Decree of 16th August 1901
Registered with the Prefecture of the Rhône department under n° W691060414

TITLE I – CREATION – PURPOSE – HEADQUARTERS – DURATION

Article 1. CREATION AND NAME

An Association named the "Association des Assurés APRIL", or abbreviated to Association 3A, was founded by private deed in Lyon on 1st January 1984. It is governed by the French Act of 1st July 1901 and the Decree of 16th August 1901.

It is a non-profit association.

On 27th April 2018 the Extraordinary General Meeting of the Association des Assurés APRIL recorded the effective completion of the merger of the Association des Assurés d'APRIL INTERNATIONAL with the Association des Assurés APRIL and the automatic dissolution without liquidation of the Association des Assurés APRIL INTERNATIONAL.

Article 2. PURPOSE

The purpose of this Association is:

- to study, research, arrange and develop all types of insurance and assistance products and services, particularly in the field of death & disability, health and retirement, in order to optimise for its Members, the purchase of supplementary or additional voluntary benefits, or benefits from the 1st euro, as required in addition to the benefits provided by the mandatory schemes, in particular by the signing of group insurance contracts with optional or compulsory membership;

- to raise awareness amongst its Members of the essential aspects of prevention in order to enable them to take care of their health on the one hand and, on the other hand, to obtain preferential terms from insurance companies which take into account the responsible behaviour of its Members in matters of health;

- to carry out statistical studies and analyses on the day-to-day behaviour of its Members in the field of health and personal risk insurance;

- to implement actions in respect of prevention, support and assistance to the Insured through an Outreach Fund.

Article 3. HEAD OFFICE

The head office is located in the 3rd district of Lyon at 114 boulevard Marius Vivier Merle.

It may be transferred by decision of the Board which has the power to amend the statutes for this purpose.

Article 4. DURATION

The association is formed for an unlimited period. It ceases to exist, however, in the event of voluntary, statutory or judicial dissolution.

TITLE II – MEMBERS AND CONDITIONS OF MEMBERSHIP

Article 5. COMPOSITION

The Association is made up of Members broken down into:

- Members;

- Members with non-salaried status;

- Group Members (companies, organisations or other legal entities) who have signed up to one of the agreements entered into by the Association on behalf of their employees.

To be a Member of the Association, you must be covered by the insurance under one of the agreements entered into by the Association and have paid the membership fee.

Member status is acquired from the date of receipt of the application for membership and payment of the membership

fee, subject to acceptance of membership of the insurance agreement by the insurer. If the application for membership is not accepted, the membership fee will be refunded no later than thirty days after notification of refusal by the insurer.

The following are also Members, but without voting rights, by decision of the Board:

- Persons or legal entities that serve or have served the Association with distinction. They are known as honorary members or members of honour;

- Persons or legal entities that have made a donation or bequest to the Association. They are known as supporting members.

Article 6. LOSS OF MEMBERSHIP STATUS

Membership is lost in the following cases:

- death, disappearance or absence for individuals;

- voluntary or legal liquidation or dissolution for legal entities;

- expulsion decided by the Board for breaches of these statutes or if conduct is found to conflict with the financial and moral interests of the Association;

- loss of insured status under one of the agreements entered into by the Association (termination, disenrollment or cancellation);

- resignation submitted to the Chairman at the Association's registered office by registered letter with proof of receipt. A copy of the letter issued by the administrator of the plan(s) confirming the termination of their insurance must be enclosed with this letter; these terminations must meet the conditions stipulated in the information notice(s) serving as the general conditions of the plan(s).

In all cases, any membership fees charged for the year in which the loss of membership status occurs will be retained by the Association.

TITLE III – LIABILITY OF AND ENFORCEABILITY ON MEMBERS

Article 7. LIABILITY OF MEMBERS

Members who have signed up to the agreements entered into by the Association are in no way personally liable for commitments made by the Association with liability being limited to the assets of the Association.

Article 8. ENFORCEABILITY ON MEMBERS

Any membership of the Association falls within the framework of the insurance agreements entered into by the Association and the insurers. The content of these agreements, in particular the conditions and consequences of termination of the agreements by the Association or the insurer, is given to Members when they join the Association and the plan in the form of an information notice serving as the general conditions.

TITLE IV – RESOURCES - EXPENSES

Article 9. ASSOCIATION RESOURCES

The Association's resources are made up of:

- the membership fees paid by Members;
- income from its property;
- sums received in return for services provided by the Association;
- grants or payments authorised by law;
- any other resources not prohibited by law.

Article 10. EXPENSES

The expenses of the Association consist of all sums necessary for its operation and representation. They are ordered by the Board or by any other person appointed by the Board for this purpose.

TITLE V – SOCIAL OUTREACH

Article 11. OUTREACH FUND

An Outreach Fund has been created for the purpose of financing support and assistance to Members.

The amount allocated annually to the Outreach Fund is decided by the Board which sets out the guidelines, missions and operating rules.

The various Outreach Actions carried out by the Association and their conditions of access and award are set out in the Association Rules and Regulations.

TITLE VI – ADMINISTRATION AND OPERATION

Article 12. BOARD OF DIRECTORS

1. Composition

The Association is managed by a Board of Directors consisting of a minimum of six (6) members and a maximum of fifteen (15) members appointed for six (6) years. The members of the Board of Directors are appointed by the General Assembly and are chosen from among the Members of the Association.

More than half of the Board members must be Members who do not hold, or have not held in the two years preceding their appointment, any interest or office in the insurance companies having signed the insurance agreements entered into by the Association and who do not receive or have not received, during the same period, any remuneration from these same insurers.

Any current Directors who take up office in, or receive any remuneration whatsoever from, one of the insurance companies having signed an insurance agreement with the Association agree to immediately notify the Chairman by registered letter with proof of receipt.

If this declaration were to reduce the number of Directors who do not, or did not during the two years preceding their appointment, hold any interest or office in the insurance organisations having signed the insurance agreements entered into by the Association and who do not or did not during the same period receive any remuneration from these insurance companies, to less than 51%, the Director in question will automatically forfeit his or her role as Director and will be replaced in accordance with article 12 of the statutes. In the event of a vacancy arising due to a death, a resignation, a Board member reaching the upper age limit or any other cause, the Board will provisionally replace these members. They will be permanently replaced at the next General Assembly. The term of office of any member elected in this way will come to an end when the term of office of the member they replaced would normally have expired.

If they are not ratified, the deliberations and actions of the Board during the period since the provisional appointment will nonetheless remain valid.

A third of the Board is renewed every 2 years. Outgoing members are eligible for re-election. The order of outgoing members is determined by the length of their term of office.

Any person aged 18 or over on the day of the election who is a Member of the Association and has paid the membership fee is eligible for Board membership.

The age limit for the position of Director is 70. If this age is reached during the term of office, the term of office will automatically end on the Director’s anniversary date.

Any new application must be brought to the attention of the Chairman of the Board by registered letter received at

least thirty days before the date of the General Assembly, together with:

- a copy of an identity document;

- a sworn declaration that no criminal convictions are held or no measures referred to in paragraphs 1 to 5 of Article L322-2 of the French Insurance Code apply;

- a certificate indicating the existence or absence of any office held with or remuneration received from any of the insurance organisations having signed an insurance agreement with the Association.

No-one can be a member of the Board of the Association, either directly or indirectly or by proxy, or administer, direct or manage the Association in any capacity whatsoever, or have the authority to sign on behalf of the Association if he or she has held any of the convictions or been subject to any of the measures referred to in paragraphs 1 to 5 of Article L322-2 of the French Insurance Code.

Each year the Board elects an executive committee by secret ballot of its members by a majority vote. This executive committee consists of a Chairman, a Vice-Chairman, a Secretary, a Treasurer and any deputies. Outgoing members of the executive committee are eligible for re-election. The Board may be assisted by any person it deems useful, whether or not they are members of the Association.

2. Board meetings

The Board meets as often as the interests of the Association require when convened by the Chairman. The Board may be convened by any means at his or her convenience.

The deliberations of the Board are minuted and recorded in a register signed by the Chairman and at least one Director.

The Board will be valid only if more than half of the Directors are present.

Decisions of the Board are taken by a majority of the Directors present. In the event of a tie, the Chairman has the casting vote. Only items on the agenda may be put to a vote.

Any member of the Board who, without justification, fails to attend three consecutive meetings may be excluded by the Board, having first been given the opportunity to comment.

3. Remuneration

Directorships are not remunerated. However, expenses and disbursements incurred in the performance of their duties are reimbursed on the basis of documentary evidence. The financial report presented at the Ordinary General Assembly must state the amount of expenses and disbursements reimbursed to Directors.

4. Powers

The Board is vested generally with the widest powers to act on behalf of the Association. It sets the amount of the membership fee payable by members of the Association.

It can delegate authority to the Chairman or to a member of the executive committee.

5. Functions and powers of the Chairman – Functions of the Secretary and the Treasurer

The members of the executive committee are specially entrusted with the following responsibilities:

1. The **Chairman** directs the work of the Board and is responsible for the running of the Association. He or she is the Association's representative in legal proceedings and in all civil acts. He or she has full authority in this respect. He or she may delegate his or her authority to another Director. In his or her absence, the Vice-Chairman will deputise.

2. The **Secretary** is responsible for correspondence, in particular for sending out the various notices to attend meetings. He or she drafts the minutes of proceedings and transcribes them in the records and carries out all formalities required by law.

3. The **Treasurer** is responsible for managing the Association's assets and accounts. He or she collects revenue and makes payments under the supervision of the Chairman. He or she submits an annual administration report to the

General Assembly in order that it may rule on the accounts.

The duties of the members of the Executive Committee may not be remunerated in any form whatsoever.

Article 13. GENERAL ASSEMBLIES

1. General Assemblies

1.1. Ordinary General Assembly

At least once a year, Members are invited to attend the Ordinary General Assembly in accordance with the procedure described above.

The General Assembly hears:
- the management report prepared by the Board covering the operation of insurance agreements entered into by the Association. This report is made available to Members who request it;
- the auditor's reports;
- the chairman's report;
- the financial report.

The General Assembly, having deliberated and ruled on the various reports, approves the accounts for the previous financial year (calendar year) and deliberates on all other points on the agenda.

It provides for the renewal of Board members under the conditions set out in Article 12 of these statutes.

1.2. Extraordinary General Assembly

Extraordinary General Assemblies are convened under the conditions set out above.

The Extraordinary General Assembly rules on matters within its exclusive jurisdiction: amendments to the statutes and mergers or dissolutions.

2. Notices to attend

2.1. Notices to attend the Ordinary and Extraordinary General Assemblies

Members of the Association, as defined in article 5 who are members on the day of the decision to issue notices to attend and who have paid their membership fee, meet at least once a year at the Ordinary General Assembly and as required at an Extraordinary General Assembly.

Meetings of Ordinary General Assemblies and Extraordinary General Assemblies consist of all Members of the Association who have paid their membership fee.

The invitation is personal and is valid if extended by the Board:

- either by letter or email sent at least sixty calendar days before the date of the General Assembly;

- or by an announcement in a publication sent out to all Members.

General Assemblies are convened by the Chairman of the Association or, for Extraordinary General Assemblies, at the request of at least 10% of Members. In this case, notices to attend the Extraordinary General Assembly must be sent out within eight days of filing the request and the Extraordinary General Assembly must be held within thirty days of these notices being sent out.

Notices to attend must specify the date, time, place and agenda planned and drawn up by the Board.

Draft resolutions signed by at least one hundred Members are also included on the agenda, if they are sent by registered letter to the Chairman of the Board at least forty-five days before the date set for the General Assembly.

Only resolutions passed by the General Assembly on items on the agenda will be considered valid.

Notices to attend must also state that, in the absence of a quorum, they serve as notices to attend a second General Assembly.

3. Voting rights

3.1. Voting rights at Ordinary and Extraordinary General Assemblies

Each Member of the Association has voting rights and one vote at Ordinary and Extraordinary General Assemblies.

Legal entity members of the Association are represented by their legal representative.

Each individual Member has the right to name another Member or his or her spouse as their proxy. A single Member cannot hold more than 5% of voting rights. The proxy vote applies to only one General Assembly, or two if a quorum is not reached at the first meeting, or if two Assemblies – one Ordinary and one Extraordinary – are held on the same day.

Blank proxy forms returned to the Association are allocated to the Chairman or to his or her delegate on the Board and enable a vote to be held on the adoption of draft resolutions presented or approved by the Board.

3.1.1. Ordinary General Assembly

Decisions of the Ordinary General Assembly are adopted by a majority vote.

All decisions are taken by a show of hands.

However, if at least a quarter of Members in attendance make the request, votes can be cast by secret ballot.

For the election of Board members, a secret ballot is compulsory.

3.1.1. Extraordinary General Assembly

Decisions of the Extraordinary General Assembly must be taken by a two-thirds majority of Members in attendance or represented.

Votes are held by a show of hands unless at least a quarter of Members in attendance request voting by secret ballot.

4. Meetings of the Assemblies

Assemblies are chaired by the Chairman of the Association who may delegate his or her duties to the Vice-Chairman or to another Director.

Proceedings are recorded in the minutes, entered in a special register and signed by the Chairman and the Secretary. The minutes are available at the Association headquarters.

An attendance sheet is completed and certified by the Chairman and the Secretary.

All Members, including those who are absent, are bound by the decisions of the General Assembly within the limits of the powers conferred by these statutes.

4.1. Meetings of the Ordinary and Extraordinary General Assemblies

Ordinary and Extraordinary General Assemblies cannot validly deliberate unless at least one thousand Members are present or represented. If, at the first meeting, the General Assembly does not reach a quorum, a second meeting of the General Assembly is convened. The meeting can then deliberate validly regardless of the number of Members present or represented.

If a quorum is not reached, the second General Assembly may be held following the first with the same agenda.

By decision of the Chairman, the Ordinary and Extraordinary General Assemblies may be held remotely using electronic voting.

Article 14. ASSOCIATION RULES AND REGULATIONS

Association rules and regulations may be drawn up by the Board of Directors to supplement the statutory provisions.

Article 15. DISSOLUTION – MERGER – TRANSFER OF ASSETS

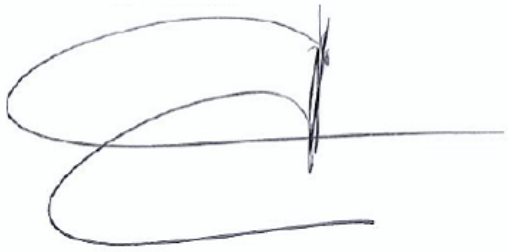
The dissolution of the Association or its merger or union with another organisation can only be approved if proposed by the Board at an Extraordinary General Assembly, in accordance with the conditions set out above.

In accordance with Article L140-6 of the French Insurance Code, in the event of the liquidation or dissolution of the Association, memberships of group insurance agreements which are active on the date of the dissolution or liquidation will continue as of right.

Article 16. LANGUAGE

These statutes are in French. If they are translated into other languages, only the French version is binding.

Pierre-Henry MICHAUD
Chairman



Jean-Louis FAVROT
Secretary