CONFIDENTIAL

Document shall be sent in a sealed envelope to :

APPN, For the attention of the medical consultant, 82 Avenue François Mitterrand - 91200 ATHIS-MONS

Medical Questionnaire

Surname: _____ Birth name: _____
Given names: _____ Date of birth: |__|__|__|__|__|__|__|__|
Place of birth: city: _____ Country: _____

Dear Madam, Dear Sir,

TO BE READ CAREFULLY

Why is this questionnaire essential?
We wish to cover most people and the smallest number of subscriptions to be denied. However, the contract needs to be appropriate to your state of health. Once established, your contract shall not be questioned: the evolution of your state of health will not lead to an increase of premiums or to the termination of your contract by us.

Do you have to declare everything?
In case of doubt, it is better to notify us of any illness or accident. An incomplete declaration would compromise your guarantees in case of a guarantee claim. Health data collected via this questionnaire will not be digitalized. It will be processed by APPN Medical Service.

It is mandatory to complete each box with YES or NO
In full letters (do not cross off or black out)

For every « YES » answer please provide the detailed information as requested

1- Have you been victim of an accident during the last 5 years?

When did it happen ? _____
Type of injuries ? _____

2-Do you keep aftereffects of this accident ?

Which ones ? _____

3- Are you or have you been affected during the past 10 years, by serious or permanent illnesses?

Which one ? _____
When did it happen ? _____

4- Do you have any infirmity, such as, for example, a visual or hearing impairment?

Which one ? _____
For how long ? _____

5- Are you undergoing any medication?

For what pathology ?

Name of the medication

For how long ?

Planned duration ?

6- Will you be hospitalized ?

When ?

Why ?

7- Have you been temporarily unfit to fly due to health issues?

Nature of the physical wounds, diseases, affections or physical deficiencies leading to this temporary unfitness to fly:

When ?

Duration ?

For what pathology ?

- **I certify that the answers above are, to my knowledge, accurate.**
- **I acknowledge that any false declaration or any reluctance likely to limit the risk concerning me shall lead to the nullity of my contract in accordance with Article L113-9 of the French Insurance Code.**
- **I authorize APPN to process my health data for internal management purposes.**

Date: |__|__|__|__|__|__|__|__|

Place: _____

Signature of the insured member

Make sure to enclose copies of any additional documents: prescriptions, post-operative reports, report of anato-pathological examinations (histology), hospitalization reports, biological examinations, report of specific further examinations. **These documents may be requested on demand, to the doctors treating your pathologies** (law of March 4th 2002).