first euro

Subscription form

L'assurance n'est plus **ce qu'elle était.**

Subscription form - Insurance policy for individuals not subject to a mandatory health insurance scheme

PRF0350

PLEASE FILL IN THE FORM USING BLOCK LETTERS

Are you already insured with APRIL Santé Prévoyance? Yes ◯ No ◯

Submitted by fax on: ⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_ Subscriber ID number: ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_

Insurance Consultant ID number: ⌊_⌊_⌊_⌊_⌊_⌊_

1

Subscriber: Mr. ◯ Mrs ◯ Miss ◯

Last name: .....

First name: .....

Maiden name: .....

Date of birth: .....

Address: .....

.....

Post code: ⌊_⌊_⌊_⌊_⌊_ City: .....

Home phone: ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_

Mobile phone: ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_

Other phone: ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_

Email address (*): .....

Marital status: .....

Number of dependent children: ⌊_⌊_

Subscriber's situation justifying his/her ineligibility for French Social Security **: .....

Sector of activity: .....

Subscriber's nationality***: .....

Subscriber's situation justifying his/her ineligibility for French Social Security **: .....

Sector of activity: .....

Spouse's nationality***: .....

***** Foreign subscribers- except for EU or Swiss citizens- must attach a copy of their Residence Permit or the temporary receipt issued by the French Administration when such an application is submitted.**

* By providing your email address, you agree to receive documents and information regarding the execution of your policy by email. You can opt-out of receiving information from us by email each time you receive such email.
** Please contact your Insurance Consultant to check in which case you are eligible to take out First Euro policy.

2

The level of coverage purchased (1): ◯ Level 1 ◯ Level 2 ◯ Level 3

First Euro desired effective date ⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_ (Subject to approval of the subscription request and to payment of your premium. No effect anterior to the day after receipt of the subscription form by APRIL Santé Prévoyance).

Fill in a medical questionnaire for each and every person to be insured.

3

Person(s) to be insured	Last name(s)	First name(s)	Date of birth	Gender (1)	Monthly premiums, all taxes included
Subscriber			⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_	◯ M ◯ F	€ .....
Spouse			⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_	◯ M ◯ F	+ € .....
1st child			⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_	◯ M ◯ F	+ € .....
2nd child			⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_	◯ M ◯ F	+ € .....
3rd child			⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_	◯ M ◯ F	+ € .....
4th child			⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_	◯ M ◯ F	Free of charge for children under 21 or € ..... (1)

I select my payment method and periodicity (5)		
Periodicity	**By direct debit**	**By check**
Yearly	◯	◯
Half-yearly	◯	◯
Quarterly	◯	Not applicable
Monthly	◯ (6)	Not applicable

(1) Children over 21 must be dependant on their parents for tax purposes.
(2) A €2.50 instalment fee is charged at each scheduled date of premium payment. Therefore, if you pay half-yearly, you will be charged twice for the amount of €2.50.
(3) Not applicable if you are already a member of the Association of APRIL's policyholders
(4) Not applicable if you have already taken out a policy with April Santé Prévoyance.
(5) Please tick the appropriate options.
(6) Minimum amount required for the monthly payment option: €16.

Monthly Premiums, all taxes included	€ .....
Instalment fee (2)	+ €2.50
Membership Fee (effective from January 1st, 2013)	+ €0.80/month (3)
Monthly Premium, all taxes included	€ .....
Processing fee (4)	+ €20
Total, all taxes included	€ .....

Please indicate your preferred monthly direct debit payment date, between the 1st and the 10th of the month ⌊_⌊_. As reimbursements are credited to the same account, if you want to receive your reimbursements to a different account, please attach the appropriate bank or postal account statement.

To date, have you benefited from this kind of coverage? ◯ yes* ◯ no (*supporting document is required)

Have you ever had a policy cancelled by either a health insurance provider or a complementary health care insurance provider? ◯ oui ◯ non

If Yes, for which reason? .....

◯ I agree my personal data may be communicated to April Santé Prévoyance's partners, so they can offer me new products and services.

"I hereby apply to join, together with the dependents stated herein, the Association of APRIL's policyholders and to take out the insurance agreement the Association took out with AXERIA Prévoyance. I hereby declare that I have read the statutes and rules of procedure of the Association of APRIL's policyholders (associationdesassuresapril.fr). **I hereby declare that I have read, approved and kept one copy of the general terms and conditions, intended for informative purposes only, under Reference Number PEU 09-11/09, as well as the benefits attached to this application form and particularly the conditions of exercise of the right of renunciation, not to mention the sample termination letter, and the general terms and conditions applicable to the management operations of APRIL. In case my policy is modified in the form of an amendment, I accept that the general terms and conditions applicable will be those mentioned above.** I acknowledge that I have been informed that the data collected are required to assess my subscription request and that administrative data are computer-processed by APRIL Santé Prévoyance and the Insurer, or their representatives, for the purposes of the execution of my subscription request for the insurance policy. Pursuant to the modified law dated January, 6 1978, I have a right of access and rectification, if applicable, of any of my personal data stated on those files by making a written request to APRIL Santé Prévoyance– Immeuble APRILIUM – 114 boulevard Marius Vivier Merle, 69439 LYON cedex 03. The recipients of your personal data, within the framework of the drawing up of the insurance application, the signing or the execution of your insurance policy are our partners, in both France and Tunisia, and any other person involved in the handling of a damage, acting as business contributors or insurers, and any professional body authorized to centralize the data included in insurance policies. Personal data collected and processed, unless you expressly requested otherwise, have been declared to the CNIL, which authorized us to proceed with the cross-border transfer of your personal data outside the European Union. I can refuse to receive commercial information regarding APRIL services and products, simply by writing to us at the above-mentioned address.

I moreover declare that my phone conversations with the Departments of APRIL Santé Prévoyance can be recorded for internal management purposes and that I can access the records related to me by sending a written request to APRIL Santé Prévoyance (at the above-mentioned address), on the understanding that each record is kept during 2 months at the latest. **I, the undersigned, certify that I have answered the above questions accurately and sincerely. I hereby certify I have nothing to report, nor omitted anything, that could mislead the insurer of the Association of APRIL's policyholders. I hereby certify not being covered by any mandatory health insurance scheme."**

Issued in ..... **On** ⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_

The stamp and the seal of the Insurance Consultant	**Signature of the Subscriber (Preceded by the mention "read and approved")**
✘	✘

Subscriber's copy

Subscriber ID number ☐☐☐☐☐☐☐☐☐

PRF0350

First Euro Medical questionnaire

You must complete the questionnaire yourself, with the greatest accuracy considering the binding nature of your statements. This medical questionnaire is essential for the insurer for risk assessment purposes. If you do not answer a question, complementary information will be then required. Any medical information provided herein is protected by professional secrecy. Try to give us as much information as you can, to help us reply within the shortest time. To preserve their confidentiality, please send the completed questionnaire in a sealed envelope, with all the requested supporting documents necessary for the medical advisor of APRIL Santé Prévoyance. Some of the medical information provided herein may be processed by computer and transferred to the Medical Advisor of APRIL. Pursuant to the modified law dated January 6, 1978, you have a right to access and rectify any personal data collected herein by making a written request to the Medical Advisor of APRIL, Immeuble Aprilium - 114 boulevard Marius Vivier Merle - 69439 Lyon Cedex 03.

Subscribers' health records

Last name: ..... First name: ..... Date of birth: ☐☐ ☐☐ ☐☐☐☐

Size: ..... cm Weight: ..... kg

		Yes	No	
1	Over the past 10 years, have you suffered from or have you been hit by one of the following? - Cardiovascular diseases (High blood pressure, heart attack, cardiopathy, arteriopathy...)? - Neurologic diseases (Epilepsy, multiple sclerosis, stroke...)? - Mental or psychological diseases (Stress, anxiety, nervous breakdown...)? - Lung diseases (Asthma, obstructive bronchitis, tuberculosis...)? - Allergic or cutaneous diseases (Eczema, psoriasis...)? - Endocrinological diseases (Diabetes, thyroid...)? - Metabolic diseases (Cholesterol, triglycerides...)? - Rheumatologic diseases, diseases of the vertebral column, bones or articulations? - Digestive or intestinal diseases? - Gynecological diseases, renal or urinary diseases? - Blood diseases (haemophilia, phlebitis)? - Ophthalmological diseases? - ENT diseases (Deafness, infection, re-emerging infections...)? - Other malignant, congenital, hereditary diseases or complaint requiring medical surveillance? *Please, attach a copy of the appropriate medical exam results, together with hospital discharge reports and /or medical consultation reports.*	○	○	If Yes, please indicate: Exact nature: .... Date of diagnosis: ☐☐ ☐☐ ☐☐☐☐ Treatment: .... Evolution: ....
2	Over the last 5 years, have you been hurt in an accident? *Please, attach a copy of the appropriate medical exam results, together with hospital discharge reports and /or medical consultation reports.*	○	○	If Yes, please indicate: - Whether it was covered by your employer's insurance or your personal accident policy? yes ○ no ○ Date : ☐☐ ☐☐ ☐☐☐☐ Nature of the initial lesions: ..... After-effects: .....
3	Over the past 10 years, have you stayed in a hospital environment or assimilated? (Hospital, rehab centre, spa treatment...)?	○	○	If Yes, please indicate: Date and duration: ☐☐ ☐☐ ☐☐☐☐ ..... Reason: .....
	Over the past 10 years, have you undergone any medical-surgical procedure (surgery, endoscopy, arthroscopy, angioplasty...)?	○	○	If Yes, please indicate: Date: ☐☐ ☐☐ ☐☐☐☐ Nature: ..... Result: .....
4	Are you or have you been on sick leave for more than a fortnight, over the past 5 years?	○	○	If Yes, please indicate: Date and duration: ☐☐ ☐☐ ☐☐☐☐ ..... Nature: .....
5	Over the past 10 years, have you undergone specific medical examinations? (Biological, imaging, scanner, MRI...) *Please provide the appropriate medical reports.*	○	○	If Yes, please indicate: Date : ☐☐ ☐☐ ☐☐☐☐ Nature: ..... Result: ..... Medical Reason: .....
6	Have you undergone serological testing particularly for Hepatitis B and C or for Human immunodeficiency (HIV)? If Yes, was the result positive?	○ ○	○ ○	If Yes, please indicate: Date: ☐☐ ☐☐ ☐☐☐☐
7	Are you or have you been under medical treatment, over the past 10 years?	○	○	If Yes, please indicate: Date and duration: ☐☐ ☐☐ ☐☐☐☐ ..... Name of treatment: .....
8	Do you receive Accident or Sickness Disability Benefits?	○	○	If Yes, please indicate: Reason: ..... Rate: ..... Duration: .....
9	Do you plan to have: - Dental care: orthodontics, dental prosthesis, braces, dental bridges, dental crowns, dental implants? - An hearing aid? - An hospitalisation, a surgery, a medical-surgical procedure (endoscopy, arthroscopy, angioplasty...)?	○ ○	○ ○	If Yes, please indicate: ..... Date: ☐☐ ☐☐ ☐☐☐☐ Nature : ..... Reason for hospitalisation: ..... *Please submit a copy of the dental quote or the hearing aid quote.*
10	Lifestyle: - Do you smoke? - Do you drink alcohol?	○ ○	○ ○	If Yes, please indicate: ..... Since when: ..... Number of cigarettes/day: ..... Number of drinks per day (20 cl glass): .....

I hereby certify that the information provided above is true and accurate and accept that these data may be transmitted to the Medical Advisor of April Santé Prévoyance. I acknowledge being informed that the coverage under the policy will be considered as null and void, terminated or reduced in case of any reluctance or intentional false statement, according to Articles L113-8 and L113-9 of the Insurance Code.

Any particular comments: .....

.....

Important - Please, turn the page to complete the medical questionnaire for Spouse. Please fill in a separate medical questionnaire for each child to be insured.

The medical questionnaire for children can be downloaded from intrapril.

Date: ☐☐ ☐☐ ☐☐☐☐

Subscriber's signature, preceded by the mention "read and approved"

✘

This questionnaire is valid for 3 months from the date of its signature.

Subscriber ID number ☐☐☐☐☐☐☐☐☐

PRF0350

First Euro Medical questionnaire

You must complete the questionnaire yourself, with the greatest accuracy considering the binding nature of your statements. This medical questionnaire is essential for the insurer for risk assessment purposes. If you do not answer a question, complementary information will be then required. Any medical information provided herein is protected by professional secrecy. Try to give us as much information as you can, to help us reply within the shortest time. To preserve their confidentiality, please send the completed questionnaire in a sealed envelope, with all the requested supporting documents necessary for the medical advisor of APRIL Santé Prévoyance. Some of the medical information provided herein may be processed by computer and transferred to the Medical Advisor of APRIL.
Pursuant to the modified law dated January 6, 1978, you have a right to access and rectify any personal data collected herein by making a written request to the Medical Advisor of APRIL, Immeuble Aprilium - 114 boulevard Marius Vivier Merle - 69439 Lyon Cedex 03.

Spouse's health records

Last name: ..... First name: ..... Date of birth: ☐☐/☐☐/☐☐☐☐

Size: ..... cm Weight: ..... kg

		Yes	No	
1	Over the past 10 years, have you suffered from or have you been hit by one of the following? - Cardiovascular diseases (High blood pressure, heart attack, cardiopathy, arteriopathy...)? - Neurologic diseases (Epilepsy, multiple sclerosis, stroke...)? - Mental or psychological diseases (Stress, anxiety, nervous breakdown...)? - Lung diseases (Asthma, obstructive bronchitis, tuberculosis...)? - Allergic or cutaneous diseases (Eczema, psoriasis...)? - Endocrinological diseases (Diabetes, thyroid...)? - Metabolic diseases (Cholesterol, triglycerides...)? - Rheumatologic diseases, diseases of the vertebral column, bones or articulations? - Digestive or intestinal diseases? - Gynecological diseases, renal or urinary diseases? - Blood diseases (haemophilia, phlebitis)? - Ophthalmological diseases? - ENT diseases (Deafness, infection, re-emerging infections...)? - Other malignant, congenital, hereditary diseases or complaint requiring medical surveillance? *Please, attach a copy of the appropriate medical exam results, together with hospital discharge reports and /or medical consultation reports.*	○	○	If Yes, please indicate: Exact nature: .... Date of diagnosis: ☐☐/☐☐/☐☐☐☐ Treatment: .... Evolution: ....
2	Over the last 5 years, have you been hurt in an accident? *Please, attach a copy of the appropriate medical exam results, together with hospital discharge reports and /or medical consultation reports.*	○	○	If Yes, please indicate: - Whether it was covered by your employer's insurance or your personal accident policy? yes ○ no ○ Date : ☐☐/☐☐/☐☐☐☐ Nature of the initial lesions: ..... After-effects: .....
3	Over the past 10 years, have you stayed in a hospital environment or assimilated? (Hospital, rehab centre, spa treatment...)?	○	○	If Yes, please indicate: Date and duration: ☐☐/☐☐/☐☐☐☐ ..... Reason: .....
	Over the past 10 years, have you undergone any medical-surgical procedure (surgery, endoscopy, arthroscopy, angioplasty...)?	○	○	If Yes, please indicate: Date: ☐☐/☐☐/☐☐☐☐ Nature: ..... Result: .....
4	Are you or have you been on sick leave for more than a fortnight, over the past 5 years?	○	○	If Yes, please indicate: Date and duration: ☐☐/☐☐/☐☐☐☐ ..... Nature: .....
5	Over the past 10 years, have you undergone specific medical examinations? (Biological, imaging, scanner, MRI...) *Please provide the appropriate medical reports.*	○	○	If Yes, please indicate: Date : ☐☐/☐☐/☐☐☐☐ Nature: ..... Result: ..... Medical Reason: .....
6	Have you undergone serological testing particularly for Hepatitis B and C or for Human immunodeficiency (HIV)? If Yes, was the result positive?	○ ○	○ ○	If Yes, please indicate: Date: ☐☐/☐☐/☐☐☐☐
7	Are you or have you been under medical treatment, over the past 10 years?	○	○	If Yes, please indicate: Date and duration: ☐☐/☐☐/☐☐☐☐ ..... Name of treatment: .....
8	Do you receive Accident or Sickness Disability Benefits?	○	○	If Yes, please indicate: Reason: ..... Rate: ..... Duration: .....
9	Do you plan to have: - Dental care: orthodontics, dental prosthesis, braces, dental bridges, dental crowns, dental implants? - An hearing aid? - An hospitalisation, a surgery, a medical-surgical procedure (endoscopy, arthroscopy, angioplasty...)?	○ ○	○ ○	If Yes, please indicate: ..... Date: ☐☐/☐☐/☐☐☐☐ Nature : ..... Reason for hospitalisation: ..... *Please submit a copy of the dental quote or the hearing aid quote.*
10	Lifestyle: - Do you smoke? - Do you drink alcohol?	○ ○	○ ○	If Yes, please indicate: ..... Since when: ..... Number of cigarettes/day: ..... Number of drinks per day (20 cl glass): .....

I hereby certify that the information provided above is true and accurate and accept that these data may be transmitted to the Medical Advisor of April Santé Prévoyance. I acknowledge being informed that the coverage under the policy will be considered as null and void, terminated or reduced in case of any reluctance or intentional false statement, according to Articles L113-8 and L113-9 of the Insurance Code.

Any particular comments: .....

.....

Important - Please fill in a separate medical questionnaire for each child to be insured.
The medical questionnaire for children can be downloaded from intrapril.

Date: ☐☐/☐☐/☐☐☐☐

Spouse's signature, preceded by the mention "read and approved"

✘

This questionnaire is valid for 3 months from the date of its signature.

[PREMIER EURO] n° adhérent : ☐☐☐☐☐☐☐☐ PRF0350

Questionnaire de santé Premier Euro Enfant

Vous devez répondre vous-même, avec la plus grande exactitude, à l'ensemble de ces questions, car vos déclarations vous engagent. Ce questionnaire de santé est indispensable pour permettre l'appréciation du risque que l'Assureur entend prendre en charge. Le défaut de réponse à l'une des questions entraînera des demandes complémentaires. Les informations médicales que vous communiquez sont couvertes par le secret professionnel. En nous apportant le maximum d'informations vous nous aiderez à vous répondre dans les plus brefs délais. Afin de préserver leur confidentialité, transmettez ce questionnaire sous pli cacheté, accompagné de toutes les pièces justificatives nécessaires au Médecin Conseil d'APRIL. Certaines informations médicales communiquées pourront faire l'objet d'un traitement informatique à l'usage du Médecin Conseil d'APRIL. Conformément à la loi du 6 janvier 1978 modifiée, vous disposez d'un droit d'accès et de rectification de toutes informations vous concernant figurant dans le fichier en vous adressant par écrit au Médecin Conseil d'APRIL, Immeuble Aprilium - 114 boulevard Marius Vivier Merle - 69439 Lyon Cedex 03.

Etat de santé Enfant

Nom : ..... Prénom : ..... Date de naissance : ☐☐ ☐☐ ☐☐☐☐

Taille : ..... cm Poids : ..... kg

		Oui	Non	
1	Souffre-t-il ou a-t-il été atteint au cours des 10 dernières années d'une maladie : - Cardiovasculaire (hypertension artérielle, infarctus, cardiopathie, artériopathie...) ? - Neurologique (épilepsie, sclérose en plaques, accident vasculaire cérébral...) ? - Psychique ou psychiatrique (stress, anxiété, dépression...) ? - Pulmonaire (asthme, bronchite obstructive, tuberculose...) ? - Allergique ou cutanée (eczéma, psoriasis...) ? - Endocrinologique (diabète, thyroïde...) ? - Métabolique (cholestérol, triglycéride...) ? - Rhumatologique, de la colonne vertébrale, des os ou des articulations ? - Digestive ou intestinale ? - Gynécologique, rénale ou urinaire ? - Du sang (hémophilie, phlébite...) ? - Ophtalmologique ? - ORL (surdité, infections, infections récidivantes...) ? - Autres maladies cancereuses, congénitales, héréditaires, affection nécessitant une surveillance médicale ? *Merci de joindre la copie des résultats des examens, les copies des comptes-rendus d'hospitalisation et/ou de consultation.*	☐	☐	Si oui précisez : Nature exacte : .... Date du diagnostic : ☐☐ ☐☐ ☐☐☐☐ Traitement : .... Evolution : ....
2	A-t-il été accidenté au cours des 5 dernières années ? *Merci de joindre les copies des comptes-rendus d'hospitalisation et/ou de consultation.*	☐	☐	Si oui précisez : A-t-il été pris en charge par votre employeur/votre assurance accident : oui ☐ non ☐ Date : ☐☐ ☐☐ ☐☐☐☐ Nature des lésions initiales : ..... Séquelles : .....
3	Au cours des 10 dernières années, a-t-il séjourné en milieu hospitalier ou assimilé (hôpital, centre de rééducation, cure...) ? Au cours des 10 dernières années, a-t-il bénéficié d'un acte médico-chirurgical (opération, endoscopie, arthroscopie, angioplastie...) ? *Merci de joindre les copies des comptes-rendus d'hospitalisation, opératoires et anatomopathologiques.*	☐ ☐	☐ ☐	Si oui précisez : Date et durée : ☐☐ ☐☐ ☐☐☐☐ ..... Motif : ..... Si oui précisez : Date : ☐☐ ☐☐ ☐☐☐☐ Nature : ..... Resultat : .....
4	Est-il ou a-t-il été en arrêt de travail de plus de 15 jours au cours des 5 dernières années ?	☐	☐	Si oui précisez : Date et durée : ☐☐ ☐☐ ☐☐☐☐ ..... Nature : .....
5	Au cours des 10 dernières années, a-t-il fait l'objet d'examens spécialisés (biologique, radio, scanner, IRM...) ? *Merci de joindre les copies des comptes-rendus.*	☐	☐	Si oui précisez : Date : ☐☐ ☐☐ ☐☐☐☐ Nature : ..... Resultat : ..... Motif médical : .....
6	A-t-il subi un test de dépistage des sérologies, portant en particulier sur les virus des hépatites B et C ou celui de l'immunodéficience humaine (HIV) ? Si Oui, le résultat a-t-il été positif ?	☐ ☐	☐ ☐	Si oui précisez : Date : ☐☐ ☐☐ ☐☐☐☐
7	A-t-il ou a-t-il été au cours des 10 dernières années sous traitement médical ?	☐	☐	Si oui précisez : Date et durée : ☐☐ ☐☐ ☐☐☐☐ ..... Nom du traitement : .....
8	Envisage-t-il : - Des soins dentaires : orthodontie, prothèses, appareils, bridges, couronnes, implants ? - Une prothèse auditive ? - Une hospitalisation, une opération, un acte médico-chirurgical (endoscopie, arthroscopie, angioplastie...) ?	☐ ☐ ☐	☐ ☐ ☐	Si oui précisez : ..... Date : ☐☐ ☐☐ ☐☐☐☐ Nature : ..... Motif d'hospitalisation : ..... *Merci* de joindre le devis dentaire ou appareillage auditif.
9	Mode de vie : - Consomme-t-il du tabac ? - Consomme-t-il de l'alcool ?	☐ ☐	☐ ☐	Si oui précisez : ..... Depuis quand : ..... Nbre de cigarettes/jour : ..... Si oui, nombre de verres par jour (20 cl) : .....

Je certifie exacts les renseignements donnés ci-dessus et déclare accepter la communication de ces informations au Médecin Conseil d'APRIL Santé Prévoyance. Je reconnais être informé(e) que toute réticence ou fausse déclaration entraînera la nullité des garanties de l'adhésion, leur résiliation ou leur réduction en application des articles L113-8 et L113-9 du Code des assurances.

Vos observations particulières : .....

.....

.....

Date : ☐☐ ☐☐ ☐☐☐☐

La signature de l'adhérent précédée de la mention "lu et approuvé"

✗

Ce questionnaire est valable 3 mois à compter de sa signature.