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C : COURTAGE

Votre spécialiste en assurance de prêt



H A B I T A T

Loan Insurance



(Master Lnl 2)

Private individual or Entrepreneur

High investment security insurance

Insurance Application - 2005

- Loans: from €310,001 to €7,600,000
- Death/TILA subscription possible up to age 65
- Reduction for non-smokers
- "Bonus" services: removal and works





Master Lnl 2

Hight investissement security insurance

Subscription application

Stamp and signature of insurance consultant

C: COURTAGE
17 Villa du Petit Parc
94000 CRETEIL
Tél. : 01 45 17 68 68

Insurance consultant no. 4.5.4.5.5

Fax sent on _____ Subscriber no. _____

Are you already insured with APRIL Assurances? YES NO

PLEASE COMPLETE THIS SUBSCRIPTION APPLICATION IN BLOCK CAPITALS

Subscriber **Company** **Private**

Company name/Name: _____
 Address: _____ Post Code : _____ Town: _____

INSURED 1 **Mr** **Mrs** **Ms**

Name: _____ First name: _____ Date of birth _____
 Social Security system subdivision: Soc Sec Self-employed Agric. Other: _____
 Status*: Executive Executive category Non-executive Profession
 Artisan Trader Farmer
 Exact profession: _____ Activity sector: _____ Employer: _____
 No. of business km/year (excluding journey between home and work): - 15,000 km/year + 15,000 km/year | Work abroad: if yes, Country: _____
 Do you regularly handle loads in your work? Yes No | Frequency of trips abroad: _____
 Do you work at a height of over 15 metres? Yes No
 Work contract: Permanent work contract Fixed term contract Temporary worker Suspension
 Seasonal worker <1/2 time Suspension of work contract; reason: _____

INSURED 2 **Mr** **Mrs** **Ms**

Name: _____ First name: _____ Date of birth _____
 Social Security system subdivision: Soc Sec Self-employed Agric. Other: _____
 Status*: Executive Executive category Non-executive Profession
 Artisan Trader Farmer
 Exact profession: _____ Activity sector: _____ Employer: _____
 No. of business km/year (excluding journey between home and work): - 15,000 km/year + 15,000 km/year | Work abroad: if yes, Country: _____
 Do you regularly handle loads in your work? Yes No | Frequency of trips abroad: _____
 Do you work at a height of over 15 metres? Yes No
 Work contract: Permanent work contract Fixed term contract Temporary worker Suspension
 Seasonal worker <1/2 time Suspension of work contract; reason: _____

* If your client is intermittent, propose Lnl Solution.

Joint information

Present address: _____ Post Code _____ Town: _____
 Email: _____
 Home phone _____ Mobile _____ Planned removal date: _____
Future address: _____ Post Code _____ Town: _____

Characteristics of loan 1

Insurance start date (date of signing loan offer) _____ **Date of 1st repayment** _____

Loan amount	Total duration of loan (including deferred amortization or pre-payment period)	Rate type	Interest rate	<input type="checkbox"/> If loan repayment other than monthly, give details: _____
_____ Euros	_____ Month	<input type="checkbox"/> Fixed <input type="checkbox"/> Variable	_____ %	

Type of loan: Classic Credit Lease Interest-only (=10 years) Successive release
 Flexible Interest-only (>10 years) Bridging loan Zero-interest loan Other: _____
 Purpose of loan: Main residence Property purchase Rental investment
 Professional investment Other: _____
 Deferred amortization or pre-payment period: No Yes Number of months _____
 Are the loan repayments constant throughout the deferred period? Yes No
 (if no, TTIW/PTD impossible for interest-only loans and loans with deferred amortization between 6 and 24 months)

Lending organisation:

Name: _____ Address: _____ Post code _____
 Town: _____ Phone _____ Fax _____
 If the delegation of benefit is to be sent to another address (branch or registered office), give details: _____
 Address: _____ Post Code _____ Town: _____
 Phone _____ Fax _____
 If the beneficiary is not the lender, send us the bank's written agreement and specify the beneficiary clause: _____



Characteristics of loan 2				
Insurance start date (date of signing loan offer) <input type="text"/>			Date of 1 st repayment <input type="text"/>	
Loan amount	Total duration of loan (including deferred amortization or pre-payment period)	Rate type	Interest rate	<input type="checkbox"/> If loan repayment other than monthly, give details:
..... Euros Month	<input type="checkbox"/> Fixed <input type="checkbox"/> Variable %	
Type of loan:	<input type="checkbox"/> Classic <input type="checkbox"/> Flexible	<input type="checkbox"/> Credit <input type="checkbox"/> Interest-only (>10 years)	<input type="checkbox"/> Lease <input type="checkbox"/> Bridging loan	<input type="checkbox"/> Interest-only (=10 years) <input type="checkbox"/> Zero-interest loan
Purpose of loan:	<input type="checkbox"/> Main residence <input type="checkbox"/> Professional investment	<input type="checkbox"/> Property purchase <input type="checkbox"/> Other:	<input type="checkbox"/> Rental investment	<input type="checkbox"/> Successive release <input type="checkbox"/> Other:
Deferred amortization or pre-payment period:		<input type="checkbox"/> No <input type="checkbox"/> Yes Number of months <input type="text"/>		
Are the loan repayments constant throughout the deferred period? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, TTIW/PTD impossible for interest-only loans and loans with deferred amortization between 6 and 24 months)				
Lending organisation: (if different from 1st)				
Name:		Address:		Post code <input type="text"/>
Town:		Phone <input type="text"/>		Fax <input type="text"/>
If the delegation of benefit is to be sent to another address (branch or registered office), give details:				
Address:				
Phone <input type="text"/>		Post Code <input type="text"/>		Town:
Fax <input type="text"/>		If the beneficiary is not the lender, send us the bank's written agreement and specify the beneficiary clause:		

Characteristics of Insurance Insured 1			
	Coverage rate DC/TILA (DC)	Coverage rate (2) <input type="checkbox"/> TTIW/PTD (AT) or <input type="checkbox"/> PTD only (1) (IT)	Total amount of premium (3)
Loan 1 % % €
Loan 2 % % €
<input type="checkbox"/> Medical Professions option + 25% (IP)	<input type="checkbox"/> Reduction for non-smokers - 25% (NF)	<input type="checkbox"/> C1 <input type="checkbox"/> C2 + 25 %	<input type="checkbox"/> C3 + 50 %

Characteristics of Insurance Insured 2			
	Coverage rate DC/TILA (DC)	Coverage rate (2) <input type="checkbox"/> TTIW/PTD (AT) or <input type="checkbox"/> PTD only (1) (IT)	Total amount of premium (3)
Loan 1 % % €
Loan 2 % % €
<input type="checkbox"/> Medical Professions option + 25% (IP)	<input type="checkbox"/> Reduction for non-smokers - 25% (NF)	<input type="checkbox"/> C1 <input type="checkbox"/> C2 + 25 %	<input type="checkbox"/> C3 + 50 %

(1) Check the option chosen.

(2) Within the limit of DC/TILA and a monthly payment of €7,600.

(3) Shown on your personalised study.

 If you have other loans, please complete the "Additional loans" form.

Payment method	<input type="checkbox"/> Direct debit	<input type="checkbox"/> Cheque (only for annual or six-monthly payment)
Frequency:	<input type="checkbox"/> monthly	<input type="checkbox"/> quarterly
	<input type="checkbox"/> six-monthly	<input type="checkbox"/> annual
Indicate the day of the month for debiting your premium, between 1 st and 10 th <input type="text"/>		Payment charge: €2.29 per payment
Subscription fee: €20 (This amount is not due if the subscriber is already insured with APRIL Assurances)		
<input type="checkbox"/> I attach a cheque in advance payment - amount (minimum €45) made out to APRIL Assurances.		

I apply for subscription to the APRIL Assurances "Association des Assurés" and its subscribed agreement with Axeria on my behalf.

"I declare that I have been informed of the statutes and internal regulations of the APRIL Assurances "Association des Assurés". I declare that I have been informed of the general terms serving as information notice reference PREM2 04-09/04 for my cover as attached to this subscription application, that I accept their provisions and have kept a copy of them, together with the terms applicable to APRIL Assurances management operations.

Within the framework of modification of my contract by means of an additional clause, I note that the general terms applicable are those of which I was informed on signature of the initial subscription application.

I the undersigned declare that I have answered all the questions asked exactly and sincerely, that I have not declared anything or omitted to declare anything that could mislead the "Association des Assurés" Insurer (it being clearly understood that sections L113-8 and L113-9 of the Insurance Code prescribe insurance nullity or reduced cover if it is proved that a false declaration has been made)."

I declare that I have been informed that my phone communications with APRIL Assurances offices may be recorded for internal management purposes.

I may obtain access to the records concerning me by sending a letter to the following address:

APRIL Assurances, 27 rue Maurice Flandin, BP 3261, 69 LYON CEDEX 403, it being understood that each record is kept for a maximum period of two months.

Signed in:(place) Date: Signature of subscriber,
preceded by the wording "read and approved"Signature of Insured 1
preceded by the wording "read and approved"Signature of Insured 2
preceded by the wording "read and approved"



Master Lnl 2

Health questionnaire

Hight investissement security insurance

Failure to reply to one of the questions may give rise to rejection of the contract subscription application.

Please answer YES or NO as applicable. If you answer YES to any question, please specify in each case:

the disease or reason for surgical operation, the dates and all other information specifically requested on the questionnaire.

Attach all necessary supporting documentation and send it in an envelope stamped confidential to the APRIL Assurances Medical Examiner.

Medical questionnaire valid for 3 months from date of signature.

Insured 1		Name: _____	First name: _____	Weight: _____	Height: _____
Solution	1	a- Do you suffer from, or have you suffered from, one of the following illnesses or diseases: hepatitis, type 1 diabetes, multiple sclerosis, cancer within the past 5 years, organ transplant, haemophilia or genetic disease?	<input type="checkbox"/> oui	<input type="checkbox"/> non	If you answer "yes" to points a and/or c of question 1, and/or one of your seropositivity tests is positive, please complete an Lnl Solution quote request. If yes, on what tests: <input type="checkbox"/> HBV result: _____ <input type="checkbox"/> HCV result: _____ <input type="checkbox"/> HIV result: _____ Reason: _____
		b- Have you had a seropositivity screening test for HBV, HCV, HIV?	<input type="checkbox"/> oui	<input type="checkbox"/> non	
c- Do you have special working hours and/or conditions for medical reasons?	<input type="checkbox"/> oui	<input type="checkbox"/> non			
if the answer to one of these questions is yes, assessment by APRIL Assurances	2	Are you suffering from or have you suffered from a disorder, a chronic or recurring illness, a disability or after-effects (accident or illness)?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Type of illness or disease: _____ When: _____ Duration: _____
	3	a- Are you at present on sick leave following an accident or illness (except legal maternity leave)?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Reason: _____ Since when: _____
		b- Have you been on sick leave for over 30 days during the past 5 years?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Reason: _____ Start date: [][]/[][]/[][][][] End date: [][]/[][]/[][][][]
	4	a- Have you had an operation during the past 10 years?*	<input type="checkbox"/> oui	<input type="checkbox"/> non	Reason: _____ When: _____
		b- Have you been admitted to hospital during the past 10 years?*	<input type="checkbox"/> oui	<input type="checkbox"/> non	Duration of hospitalisation: _____ Reason: _____ When: _____ Duration of hospitalisation: _____
	* except for maternity, appendicitis, tonsils, adenoids, varicose veins, wisdom teeth, bladder, hiatus or inguinal hernia, haemorrhoids, deviation of the nasal septum, caesarean, voluntary termination of pregnancy.				
	5	Do you have or have you had any rheumatic illnesses or vertebral/disc disorders?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Which: _____ Area of injuries: _____ Since when: [][][][]/[][][][]
	6	Have you had any injuries to your joints, muscles or ligaments during the past 5 years?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Which: _____ Area of injuries: _____ Date: [][][][]/[][][][]
	7	Do you take or have you taken medical treatment for:			Reason: _____
		- a cancerous disease,	<input type="checkbox"/> oui	<input type="checkbox"/> non	_____
		- a neurological disorder (e.g. epilepsy, etc.),	<input type="checkbox"/> oui	<input type="checkbox"/> non	_____
		- a psychiatric disorder (e.g. nervous breakdown, etc.),	<input type="checkbox"/> oui	<input type="checkbox"/> non	Which: _____
- a metabolic disorder (e.g. cholesterol, triglycerides, diabetes, etc.),		<input type="checkbox"/> oui	<input type="checkbox"/> non	_____	
- a pulmonary disease (e.g. asthma, etc.),		<input type="checkbox"/> oui	<input type="checkbox"/> non	_____	
- a cardiac or vascular disease (e.g. hypertension, etc.),		<input type="checkbox"/> oui	<input type="checkbox"/> non	_____	
- a rheumatic disease (e.g. lumbago, sciatica, etc.),	<input type="checkbox"/> oui	<input type="checkbox"/> non	_____		
- an endocrine disorder (e.g. thyroid, etc.),	<input type="checkbox"/> oui	<input type="checkbox"/> non	_____		
- or for any other illness with treatment for over a month (e.g. renal, urinary, genital or hepatic disorder, infectious illnesses, etc.).	<input type="checkbox"/> oui	<input type="checkbox"/> non	Since when: _____ Duration of treatment: _____		
8	Are you or have you been under medical supervision? (excluding occupational medicine and systematic follow-up during pregnancy)	<input type="checkbox"/> oui	<input type="checkbox"/> non	Why: _____ Since when: _____	
9	Do you have an eye disease or severe myopia less than 8/10 after correction, or blindness in one or both eyes?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Reason: _____ Treatment or correction: Right eye: _____ Left eye: _____	
10	For women only: are you pregnant?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Since when: _____	
11	a- Do you practise a sport within the framework of amateur competitions and/or as a member of a federation and/or a club?	<input type="checkbox"/> oui	<input type="checkbox"/> non	If yes, which: _____ If this sport is shown in the list of specific sports on the back of this document, do you want to be covered for this sport: <input type="checkbox"/> yes (1) <input type="checkbox"/> no	
	b- Do you practise one of the following sports: bobsleigh, snowmobile, ski-bob, skeleton, scuba diving or fishing, sailing, potholing, climbing, mountaineering, bungee-jumping, canyoning, catamaran.	<input type="checkbox"/> oui	<input type="checkbox"/> non	If yes, which: _____ How often: _____ Do you want to be covered for this sport <input type="checkbox"/> yes (1) <input type="checkbox"/> no	
12	Do you practise an aerial activity?	<input type="checkbox"/> oui	<input type="checkbox"/> non	Which: _____ Do you want to be covered for this activity <input type="checkbox"/> yes (1) <input type="checkbox"/> no	

(1) Subject to acceptance by APRIL Assurances, which will be mentioned on the subscription certificate.

CAUTION: You must answer all the questions, from 1 to 12.

I, the undersigned, declare that I have answered the above questions exactly and sincerely, and that I have not declared anything or omitted to declare anything that could mislead the insurers.

Signed in _____ Date [][][][]/[][][][]

Signature of Insured 1

Operation of the health questionnaire:

Questions 2 to 12: if you answer one of these questions in the affirmative, a medical assessment will be carried out by the APRIL Assurances medical examiner in order to determine the amount of your premium. By giving us as much information as possible, you will help us to give you an answer as soon as possible.



List of specific sports*

- **Equestrian sports:** horse shows, hurdling, cross country, polo, rodeo.
- **Motor sports:** hill-climbing, speed trials, Formula 1-2-3, go-karting, rallies, long-distance rallies, stock car.
- **Motorbike sports:** circuit racing, hill-climbing, endurance, enduro, motocross, quad in competition, long-distance rallies, speedway, trial.
- **Winter sports:** competition sledging, competition skating, extreme skiing.
- **Water sports:** rafting, jet ski, outboard racing, offshore racing, navigation over 20 miles from coast.
- **Boxing and martial arts** in competition, **American football** (if TTIW/PTD waiting period is 30 days), **amateur rugby** (if TTIW/PTD waiting period is 30 days), competition **mountain biking, triathlon**.

* If you want to be covered for one of the sports shown in this list, an assessment of your application will be required.

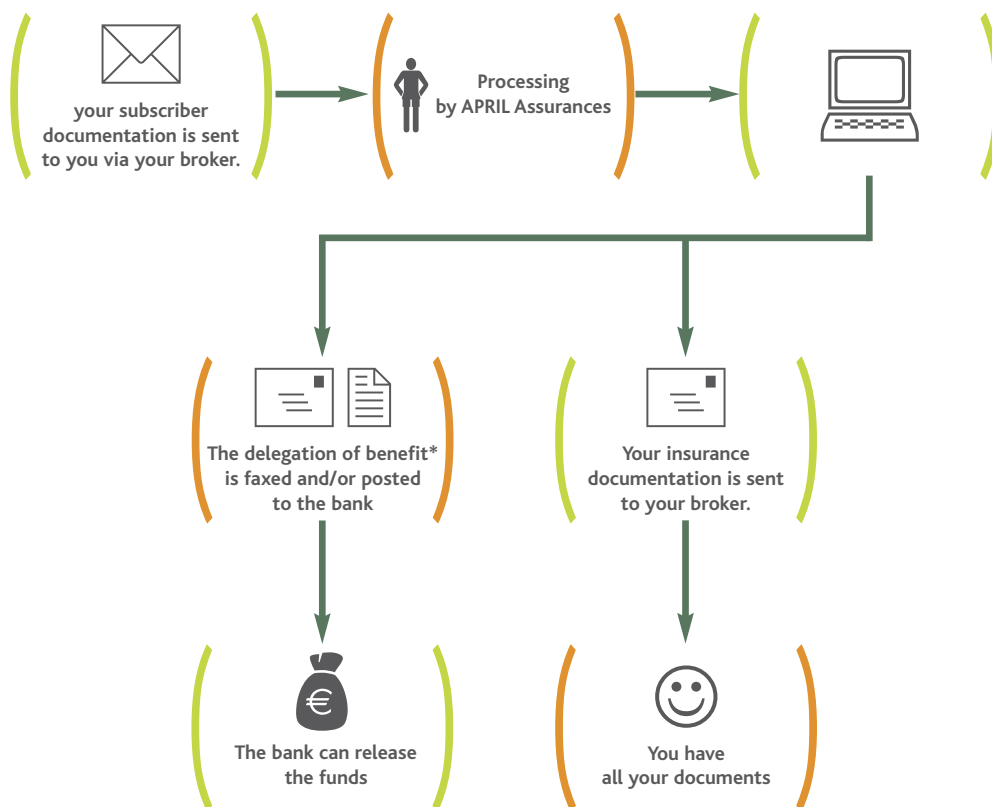
I enclose

- **My subscription application: completed, dated and signed by the 2 insured parties,**
- **My direct debit authorisation: completed and signed,**
- **My bank or post office account identification slip,**
- **My cheque for the advance payment: made out to APRIL Assurances,**
- **Supporting medical documentation, etc.**
- **Copy of the loan agreement.**



And after subscription?

Your subscription application is processed as soon as it is received by APRIL Assurances: your subscriber documentation is sent to you via your broker. Your delegation of benefit* is sent directly to your bank, so that your loan can be released as soon as possible;



* Delegation of benefit:

- The bank becomes the beneficiary of your insurance throughout the term of your loan.
- The capital on death or your loan repayments in the case of work stoppage (if this option is subscribed), are repaid directly to it.
- Any modification to the contract must be made with the agreement of your bank.



The APRIL Assurances offer

APRIL Assurances designs, manages and distributes simple and innovative insurance solutions to a network comprising 11,400 independent insurance consultants in France.

Its fields of expertise are wide and diversified, enabling it to offer a response to the widest possible range of insurance requirements: families, seniors, students, travellers, borrowers, directors, employees, self employed workers, etc. APRIL Assurances cover is clear, comprehensible and accompanied by numerous services offering additional convenience to everyone.

Areas of expertise



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Phone 0 891 46 6000
(€0.23 inc. VAT/min)



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Your **satisfaction**

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- 96% of insurance consultants satisfied (IPSOS results 2004).



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Automobile and home insurance solutions.

Key figures

- APRIL Assurances founded in 1988,
- Division of APRIL GROUP, **listed on the "Second Marché" of the Paris bourse,**
- **1 million** people insured individually or through their employers,
- **A network of 11,400 independent insurance consultants** distributed throughout French territory,
- 550 staff.

Your Insurance Consultant

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