



PLEASE SEND THIS FORM BY EMAIL TO: info@carps.fr

or by post to:

CARPS International

168 rue de Grenelle - 75007 Paris - FRANCE

PLEASE ATTACH A COPY OF YOUR BANK ACCOUNT N° (WITH SWIFT, IBAN, BANK ADRESSE)

APPLICATION FORM

Embassy _____

Contract N° _____

Subsidiary N° _____

If there is already a contract with your Embassy

Starting date of coverage

The first of each month

day month year

LAST NAME _____

FIRST NAME _____

Maiden name _____

Date of birth

day month year

Sex

M/F

Height _____

Weight _____

Nationality _____

Country of origin _____

Country of Residence _____

Date of assignment
to country of Residence

month year

Position _____

E-Mail _____

Please indicate your EMAIL in order to receive your personal reimbursement statement. Use one EMAIL for whole family

Mobile phone _____

Conforming to the Data Protection Act established January 6th 1978 and general regulation concerning data protection dating from May 25th 2018, private data collected as part of the present contract shall be processed so as to effectively manage and execute your health insurance contract. By signing this document, you expressly provide your consent to the processing of your private data. No commercial use will be made using your private data.

By enforcing existing legislation, you may exercise your right to access, modification, and opposition to the use and processing of your private data by writing via air mail or by email to the delegation for data protection: info@carps.fr / CARPS International, 168 rue de Grenelle, 75007 Paris.

I hereby certify that I have not been ill within the last 6 months and that, to the best of my knowledge, I am in good health.

I hereby certify that I am not entitled to any other health insurance system.

day month year

*Signature with Stamp of the
Embassy or Representative
Office*