



## APPLICATION FOR CHILD MEDICAL BENEFITS (to be completed by the head of the household)

**This application only applies to children where the head of the household, of a nationality other than French or Monegasque, lives in France.**

### IDENTIFICATION OF THE INSURED

Surname and first name: ..... Maiden Name: .....  
 Date of birth: \_\_\_ / \_\_\_ / \_\_\_ Nationality : ..... CCSS ID Number: .....  
 Address: .....

### INFORMATION ABOUT THE CHILD

The undersigned,  Mr  Mrs (Surname and First name) .....

- Certifies that they are responsible for the child (Surname and First name): .....

Date of birth of the child: \_\_\_ / \_\_\_ / \_\_\_ Sex of the child:  Male  Female

- Declares to be the (state the degree of relationship).....of the child.  
 who lives at ..... (*only complete if the child does not live under the same roof as the head of the household*)  
 who is raised by (state the degree of relationship)..... residing at .....

### TO BE COMPLETED IF APPLICATION IS PRESENTED BY THE MOTHER

I the undersigned, (Surname and First Name) .....  
 hereby certify:

that my spouse is not engaged in any occupational activity,  
 that I live alone with my child(ren),  
 that I have been co-habiting since \_\_\_ / \_\_\_ / \_\_\_

with: (Surname and First name of the partner): .....  
 Nationality: ..... Place of work: ..... ID number: .....

I hereby certify that the information provided above is accurate.

Date : \_\_\_ / \_\_\_ / \_\_\_ Signed by the insured:

### SUPPORTING DOCUMENTS TO BE PROVIDED

- A photocopy of the family record book,
- If the child is of school age, a school attendance certificate,
- In the event of a divorce or separation, a photocopy of the order pendente lite or judgement ruling on the child's custody.

**Any incorrect information may result in steps being taken to recover the cost of care**