



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

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