ApolloMunich HEALTH INSURANCE
Apollo Munich Health Insurance Co. Ltd.
10th Floor, Tower-B, Building No. 10,
DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

PROPOSAL FORM

Application No. : _____

We are under no obligation to accept any proposal for insurance. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if premium is not received by us in full and in time, or not realised.

Please fill-up this in CAPITAL LETTERS and attach a passport size photograph of yourself and each proposed insured person and write the name of the person above the photograph.

PROPOSER DETAILS

Proposer : (Mr/Mrs/Ms) | First Name | Middle Name | Last Name

Address :

City/Town

District : | State

Pin code : | Mobile

Telephone : | E Mail

Nationality : _____ Marital Status _____ Annual Income : _____

Profession : Salaried ☐ Self Employed ☐ Others ☐ Details .....

ID Proof Type : PAN ☐ Passport ☐ Driving Licence ☐ Voter's card ☐ Others ☐

ID Proof No. :

2. PLAN DETAILS

Plan : Standard ☐ Exclusive ☐ Premium ☐ Type : Individual ☐ Floater* ☐

Proposed Policy period : From D D M M Y Y Y Y To D D M M Y Y Y Y

3. PROPOSED INSURED(S) DETAILS

Details of Person Proposed to be Insured

Insured 1. Name: Mr./Ms./Mrs.

Height cms | Relationship | Date of Birth D D M M Y Y Y Y | Occupation

Weight kg | Gender* | Sum Insured* | CI Sum Insured**

Insured 2. Name: Mr./Ms./Mrs.

Height cms | Relationship | Date of Birth D D M M Y Y Y Y | Occupation

Weight kg | Gender* | Sum Insured* | CI Sum Insured**

Insured 3. Name: Mr./Ms./Mrs.

Height cms | Relationship | Date of Birth D D M M Y Y Y Y | Occupation

Weight kg | Gender* | Sum Insured* | CI Sum Insured**

Insured 4. Name: Mr./Ms./Mrs.

Height cms | Relationship | Date of Birth D D M M Y Y Y Y | Occupation

Weight kg | Gender* | Sum Insured* | CI Sum Insured**

Insured 5. Name: Mr./Ms./Mrs.

Height cms | Relationship | Date of Birth D D M M Y Y Y Y | Occupation

Weight kg | Gender* | Sum Insured* | CI Sum Insured**

Insured 6. Name: Mr./Ms./Mrs.

Height cms | Relationship | Date of Birth D D M M Y Y Y Y | Occupation

Weight kg | Gender* | Sum Insured* | CI Sum Insured**

* Gender Code M (Male), F(Female) * Floater policy will have same Sum Insured for all members (See brochure for floater policy details)

** Critical illness (Critical illness Sum insured would be 50% or 100% of the Sum Insured and the same rule is applicable for all members)

Please paste the photographs in sequence (Insured 1, Insured 2, Insured 3, Insured 4, Insured 5, Insured 6) as specified in section 3 of details of proposed to be insured

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

4. NOMINEE DETAILS

In the event of the death of an insured person any payment due under the policy shall become payable to the nominee and his/her receipt of the proceeds would be sufficient discharge to the company. The nominee must be an immediate relative of the Proposer. Nominee for all other persons proposed to be insured shall be the Proposer himself/herself. The following section is to be filled by the Proposer

Nominee Name	Relationship	Address of the Nominee

5. PREVIOUS/EXISTING INSURANCE DETAILS

Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy for in-patient hospitalisation with Apollo Munich Health Insurance Company Limited or any other insurance company? If yes, please indicate below the Policy/ Application number(s) (Please mention application number incase of pending proposal.

Since when are you continuously insured: **(If required kindly attach extra sheet duly signed)**

Do you want to consider these details for continuity Yes | No

Policy No./Application No.	Insurer	From (Date)	To (Date)	Sum Insured	Claim details (if any)
		D D M M Y Y	D D M M Y Y		
		D D M M Y Y	D D M M Y Y		
		D D M M Y Y	D D M M Y Y		

6. MEDICAL & LIFE STYLE INFORMATION

Medical History: Please answer the below mentioned questions in Yes(Y)/No(N): (If required kindly attach extra sheet duly signed)

Section A: Have any of the insured ever suffered from/currently suffering from any of the following:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
i Hypertension, Chest Pain, Ischemic heart disease or any other cardiac disorder						
ii Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder						
iii Ulcer(Stomach/Duodenal), Hepatitis, Cirrhosis or any other digestive or liver/gall bladder disorder						
iv Renal Failure, Calculus or any other kidney/urinary tract or prostate disorder						
v Dizziness, Stroke, Epilepsy, Paralysis or any other brain/nervous system disorder						
vi Diabetes, Thyroid Disorder or any other endocrine disorder						
vii Tumor-benign or malignant, any ulcer/growth/cyst						
viii Arthritis, Spondylosis or any other disorder of the muscle/bone/joint						
ix Diseases of the Nose/Ear/Throat/Dental/Eye (please mention Dioptres)						
x HIV/AIDS or sexually transmitted diseases or any immune system disorder						
xi Anaemia, Leukaemia or any other blood/lymphatic system disorder						
xii Psychiatric/Mental illnesses or sleep disorder						
xiii DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder (for female lives only)						
Section B: Have any of the insured persons						
xiv Been addicted to alcohol, narcotics, habit-forming drugs or been under detoxication therapy						
xv Been under any regular medication (self/prescribed)						
xvi Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5years						
xvii Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending						
xviii Suffered from any other disease/illness/accident/injury						
xix Is any of the proposed insured pergnant? If yes, please mention the expected date of delivery						
xx Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy						

section C: Name & Details of illness/Medicine/Test/Surgery/ diopter grade(for questions answered as Yes in Sections A & B)	Diagnosis Date	Date of Last Consultation	Treatment in/out patient	Doctor/Hospital Name & Phone No.
Insured 1:				
Insured 2:				
Insured 3:				
Insured 4:				
Insured 5:				
Insured 6:				

Section D: Name, address, qualification and contact details of the family doctor:	
Name :	
Address :	
Qualification :	Mobile
E Mail :	

Section E: Does any person proposed to be insured smoke or consume gutkha/pan masala or alcohol? If yes, please indicate the name and quantity per week.	**Alcohol**	**Smoke**	**Pan Masala**	**Others**
Insured 1:				
Insured 2:				
Insured 3:				
Insured 4:				
Insured 5:				
Insured 6:				

7. PAYMENT DETAILS

Instrument type (Cash/Cheque/Debit Card/Credit Card/others)	Instrument No.	Name of the Premium Payor	Bank Details	Date	Amount (in Rs)

Please make a Crossed Cheque/DD/Pay Order in favour of 'Apollo Munich Health Insurance Company Limited' only.

Section 41 of Insurance Act1938(Prohibition of rebates):

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

2) Any person making default in complying with the provision of this section shall be punishable with fine which may extend to five hundred rupees.

8. ADDITIONAL INFORMATION

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

9. GENERAL EXCLUSIONS

Following is an outline of the general exclusions under the policy. For more details on the exclusions & waiting periods please refer the policy wordings before purchasing this policy.

War or any act of war, invasion, act of foreign enemy, war like operations, nuclear weapons/materials radiation of any kind, committing or attempting to commit a criminal or illegal act, participation or involvement in naval, military or air force operation or any hazardous or dangerous or adventurous activities, including but not limited to racing, diving aviation, scuba diving, motorcycling, parachuting, hang-gliding, rock or mountain climbing, abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol, smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment of services, intentional self injury or attempted suicide, obesity/morbid obesity and any weight control program, psychiatric, mental disorders, Parkinson and Alzheimer's disease, general debility or exhaustion 'run-down condition', congenital internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy, AIDS (Acquired Immune Deficiency Syndrome) and /or infection with HIV (Human immunodeficiency virus), venereal disease, sexually transmitted disease, sterility/infertility treatment of any type, pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or illness) except in the case of ectopic pregnancy, treatment of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means (except treatment of fractures and dislocations of the extremities), dental treatment not requiring hospitalisation, nasal septum deviation and nasal concha resection, circumcisions, laser treatment for refractive error, aesthetic or change-of-life treatment, plastic surgery or cosmetic other than for reconstruction following an Accident or illness otherwise covered under this Policy, experimental, investigational or unproven treatment devices and pharmacological regimens, measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment, convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care, all preventive care, vaccination including inoculation and immunisation, any non-allopathic treatment, enteral feedings and other nutritional and electrolyte supplements, unless required as a direct consequence of an otherwise covered claim, charges related to a Hospital stay not expressively mentioned as being covered, personal comfort and convenience items, vitamins and tonics, treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed, out-station consultations and referral-fees, treatment by Medical and non-Medical Practitioner and clinics from where the bills have been excluded for payments by the insurer for certain reasons, treatment rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of an Insured Person's Family, the provision or fitting of

hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, diabetic test strips, and similar product, any treatment that is not of a reasonable cost, not medically necessary; non-prescription drugs, crutches or any other external appliance and/or device used for diagnosis or treatment.

This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its terms. Non-compliance may result in avoidance of the Policy. If there is insufficient space for you to provide information, whether as requested or otherwise, please attach a separate sheet.

You are obliged to inform Apollo Munich Health Insurance Company Limited without any delay & in writing of all doctors or other members of medical profession whom you or any of the proposed member/s have consulted & all changes in your or any other proposed member's state of health between the filing of this application form & inception of your insurance cover. If you are in any doubt, please seek advice of your insurance advisor.

10. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

I hereby declare and warrant on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects and there is no other information which is relevant to this application for insurance that has not been disclosed to Apollo Munich Health Insurance Company Ltd. I agree that this proposal and the declarations shall be the basis of the contract between me and all persons to be insured and Apollo Munich Health Insurance Company Ltd. I further consent and authorize Apollo Munich Health Insurance Company Ltd. and/or any of their authorized representatives to seek medical information from any hospital/consultant that I or any person proposed to be insured has attended or may attend in near future concerning any disease or illness.

Signature of the Proposer **Signature of the Advisor**

Date:

Place:

Vernacular Declaration

Certification in case the Proposer has signed in vernacular (to be witnessed by someone other than the agent / employee of the company):

Name of Proposer:

The contents of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same:

Signature of Proposer Signature of the Witness:

Date: Place: Name of the Witness:

Insurance is the Subject Matter of the Solicitation

How did you come to know about our company / health insurance products:

☐ Television Ad ☐ Radio Jingle ☐ Hoarding ☐ Point of Sale ☐ Word of Mouth

☐ Road Show ☐ Exhibition Counter ☐ Sponsor Program ☐ Brochure ☐ Newspaper / Magazine

☐ Others, please specify _____

11. FOR OFFICE USE ONLY

Apollo Munich Office Code:	:	Advisor Code & Name:	
Branch Receipt Date	:	Channel Type	:
Business Type	: Urban / Rural / Social		

12. CHECK LIST

Please check the following documents are attached along with the proposal form

1. ID Proof : Passport / PAN Card / Voter's Identity Card / Driving License / Letter from a recognised public authority
2. Proof of Residence : Telephone Bill / Bank Account Statement / Letter from any recognised public authority / Electricity Bill / Ration Card
3. Age Proof : Proof of Age
4. Renewal notices with claim details:
5. Certification of previous insurance for previous claim details:
6. Photocopies of all previous policies and endorsements :