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Maxima Proposal Form



10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Application No. : _____

The information provided by me in this document is <u>True to the best of my knowledge</u> .	
	Signature of Proposer:

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 price, terms, conditions and exclusions. Non-compliance may result in the avoidance of the Policy. If there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the advice of your insurance advisor. 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 under the Policy if premium is not received by Us in full and in time, or is not realised.

Please fill-up this form in CAPITAL LETTERS and attach a passport sized photograph of yourself and each proposed insured person and write the

name of the person above 1. PROPOSER DETAILS		ie p	hote	ogra	ıph.																													
Proposer : (Mr./Ms./Mrs.)																														Т				
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Critical Illness opted :	Yes				1		No																- [
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3. PROPOSED INSURE Details of Person Proposed																																		
Insured 1 : Name : Mr./Ms.	/Mrs	s.																																
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Insured 4 : Name : Mr./Ms.	/Mrs	S.																																
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Insured 1									ured										Insur											ured	14			

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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 in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.

Nominee	Namo						Dal	atio	nel	hin					Λ.	ddress of th	o Nominoo	
Monninee	Name						nti	auv	11121	ıııp					A	uuress oi u	ie nomme	
5. EXISTING/PREVIOUS	INSURANCE DETAILS																	
s the proposer or any of the policy issuance? If yes, pleas	persons proposed, alread	,								•					•	,		al pending for
Since when are you continuo	usly insured:	М	Υ	Υ							(If re	quir	ed kindl	y attach extra s	sheet with rel	evant details	s, duly signed)
Do you want Apollo Munich H	ealth to consider these de	etails	s foi	COI	ntinu	uity (of yo	our (exis	sting	Не	alth	Insu	ırance F	Policy? 🗆 Yes	s □No		
Policy No./Application No.	Insurer		Fr	om	(Da	te)			1	To (I	Dat	e)		Su	m Insured	Claim de	etails for la (if any)	st 3 years
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6. MEDICAL AND LIFE S Medical History: Please answ		ues	tion	s Ye	s (Y)	or I	No (N):							swer these quest coverage in case		Signature (of the Proposer

	A : Have any of the persons proposed to be insured ever suffered from/are currently g from any of the following :	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4
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/ gallbladder disorder				
iv.	Renal failure, Calculus or any other kidney/urinary tract or prostate disorder				
V.	Dizziness, Stroke, Epilepsy, Paralysis or 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/Teeth/ Eye (please mention Diopters)				
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				
Section	B : Have any of the persons proposed to be insured:				
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 5 years?				

Section C : Name and Details of Illness/Medicine/Test/Surgery/ Diopter grade (for questions answered as Yes in Section A & B)	Diagnosis date	Date of last consultation	Treatment In/ Outpatient	Doctor/Hospital Name & Phone No.
Insured Person 1				
Insured Person 2				
Insured Person 3				
Insured Person 4				

Undertaken any surgery or been advised surgery in the last 10 years or have a surgery still pending?

Been informed that they are Pregnant? If yes, please mention the expected date of delivery

Had any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy?

Suffered from any other disease/illness/accident/injury?



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Insured Person 2 :																												+			
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Insured Person 4 :																															
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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 breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane, participation or involvement in naval, military or air force operation or any hazardous or dangerous or adventurous activities including but not limited to racing, driving, aviation, scuba diving, 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 or services or supplies, treatment of obesity or 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, sleep apnoea, veneral disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus), 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 and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, muscle stimulation by any means except for treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities, dental treatment not requiring hospitalization, treatment of nasal concha resection, circumcisions unless medically necessary, laser treatment for correction of eye due to refractive error, aesthetic or change-of-life treatments, plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment for reconstruction





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

☐ The product details including the limited number of provider network has been explained to me and I have understood the same. 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 that there is no other information which is relevant to this application for insurance that has not been disclosed to Apollo Munich Health Insurance Company Limited. 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 Limited. I further consent and authorise Apollo Munich Health Insurance Company Limited 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 future concerning any disease or illness or injury. ☐ I authorize Apollo Munich Health Insurance and associate partners to contact me via e-mail, phone or SMS. Date: Signature of the Proposer Place: **Vernacular Declaration:** Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the company): Name of the Proposer: The content 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 the witness: Signature of the Proposer: Date: Name of the witness: Place: Insurance is the subject matter of solicitation 11. AGENT'S DECLARATION (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this proposal form to the Proposer including statement(s), information and response(s) submitted by him/her in this proposal form to questions contained herein or any details sought herein will form the basis of the contract of Insurance between the Company and the Proposer, if this proposal is accepted by the company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this proposal form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the company as null and void and all premiums paid under the Policy may be forfeited to the company. License No. (Advisor/Corporate Agent/Broker/Relationship Officer): Place: Date: Signature of Agent: 12. CHECKLIST Please check the following documents are attached along with the proposal form ID Proof: Passport/ Pan Card/Voter ID card/Driving License/ Letter from a recognized public authority 1. 2. Proof of residence: Telephone Bill/ Bank Account Statement/ Letter from any recognized public authority/ Electricity Bill/ Ration Card 3. Age Proof: Passport/PAN/Driving License/Birth Certificate/School Certificate 4. Renewal Notice with claim details 5. Certification of previous insurer for previous claim details 6. Photocopies of all previous policies and endorsements 13. FOR OFFICE USE ONLY Apollo Munich Health Office Code Advisors Code & Name:

AMHI/PR/H/0013/0045/102010/P

Rural/ Social /Other

Branch Receipt Date

Business Type

Channel Type:

Broker: Vibhuti Insurance Brokers Pvt Ltd.

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