TOLL FREE 1800-102-0333 • www.apollomunichinsurance.com • E-mail : customerservice@apollomunichinsurance.com

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

Application No.: _____

PROPOSAL FORM

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 is not realised. Please fill-up this form in CAPITAL LETTERS.

PROPOSER DETAILS

Proposer : (Mr./Ms./Mrs.)			
First Name	Middle name	Last Name	
Address:			
City/Town:	District:		
State:		PIN Code:	
E- Mail:			
Contact details (India):	Contact details (Overseas):		

Nationality :

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

Occupation (nature of duties) :.....

PLAN DETAIL(S) (Please refer to the brochure for details of benefits under plans & select the appropriate option below)

Type: Individual ☐ Family ☐ Senior Citizen ☐ Annual Multi-trip 30 days ☐ Annual Multi-trip 60 days ☐

Plan: Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Asian Region ☐

Geography: Worldwide ☐ Worldwide excluding USA & Canada ☐ Asia Pacific excluding Japan ☐

Proposed Policy Period	From	D	D	M	M	Y	Y	Y	Y	To	D	D	M	M	Y	Y	Y	Y

PROPOSED INSURED(S) DETAILS: Name of the persons proposed to be insured (including proposer)

S No.	Mr./Ms./Mrs. Name of the person to be insured	Relationship to the Proposed Insured	Gender Male Female	Date of Birth (DDMMYY)	Passport Number
1					
2					
3					
4					
5					
6					

NOMINEE DETAILS

In the event of the death of an Insured Person any payment due under the Policy will be payable to the Nominee in accordance with the Policy terms and conditions. Please give below the details of the Nominee, who must be an immediate relative of the Proposer. Nominee for all other persons proposed to be insured shall be the Proposer

Nominee Name	Relationship to the Proposed Insured	Address of the Nominee

EXISTING INSURANCE DETAILS

Is the proposer or any of the persons proposed, already insured under or proposed for a personal accident insurance policy with Apollo Munich Health or any other insurance company? If yes, please indicate below the Policy/Application number(s) (Please mention application number incase of pending proposal):

Policy No. / Application No.	Insurer	From (Date)	To (Date)	Sum Insured
		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	

MEDICAL & LIFE STYLE INFORMATION (if your answer to any of the below is 'yes', kindly attach the details in an extra sheet duly signed)

Are You suffering from or have You ever suffered from any of the following (please encircle): arthritis, allergies, circulatory disorder, cancer of any kind, diabetes, disorders of the spinal cord or vertebral column like slipped disc etc, disorders of the stomach / large or small intestine, high blood pressure, heart condition, hernia of any kind, hemorrhoids, hematological (blood) disorder, mental condition, nervous disorder, fainting episode, blackouts, fits, paralysis of any kind, respiratory disorder, urinary disorder, varicose veins or any diseases or injury requiring surgical or medical treatment.

If Your answer is 'yes' to any of the above, please provide details : _____

ApolloMunich HEALTH INSURANCE

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

Please provide name and contact details of Your treating or family doctor : _____

PAYMENT DETAILS

Instrument type Cash/Cheque/Debit/Credit Card/ Others	Instrument No.	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 Act 1938 (Prohibition of Rebates): 1) No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out 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 provisions of this section shall be punishable with fine which may extend to five hundred rupees.

ADDITIONAL INFORMATION

[If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach a separate sheet to this proposal and return it to us.]

GENERAL EXCLUSIONS

Following is an outline of the exclusions under the policy. Specific additional exclusions apply to various benefits under the policy. For more details on the exclusions & waiting periods please refer the policy wordings before purchasing this policy.
We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy: War, war like operations; nuclear weapons/materials radiation of any kind; committing or attempting to commit a criminal or unlawful act; participation or involvement in naval, military or air force operation or any hazardous ; abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol; treatment of nicotine addiction or any other substance abuse; intentional self injury or attempted suicide; obesity/morbid obesity and any weight control program; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus), venereal disease, sexually transmitted disease; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; non allopathic treatment; 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; treatments by a Medical Practitioner who shares the same residence as an Insured or 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 products; any treatment that is not medically necessary; where purpose of travel is to obtain medical treatment; treatment of any pre-existing condition, cancer, orthopedic, degenerative or oncology diseases unless to save life in an unforeseen emergency or to relieve acute pain; cosmetic treatment; congenital internal or external disease.

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 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 doubt, please seek the advice of your insurance advisor.

DECLARATION & WARRANTY ON BEHALF OF ALL THE 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 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 its 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.

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

Date: Place:

INSURANCE IS THE SUBJECT MATTER OF SOLICITATION

FOR OFFICE USE ONLY

Apollo Munich Health Office code:

Advisor code & Name: 80088870 AATISH AGRAWAL

Branch Receipt date:

Channel Type:

Business Type: Urban / Rural / Social