

Application No. : _____

THIS PLAN IS NOT AVAILABLE TO PERSONS WHO HAVE/ EVER HAD ANY CANCER (Including Leukemia, Lymphoma & Sarcoma) OR ANY PRECANCEROUS CONDITION OR EVER HAD/ AWAITING ORGAN TRANSPLANTATION

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 avoidance of the Policy. If there is insufficient space for You to provide information, whether as requested or otherwise, please attach a separate sheet. Incomplete/incorrect/partially correct information will lead to cancellation of proposal and policy even if it is issued. If You are in any doubt, please seek 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

1. PROPOSER DETAILS

The Central Government has made Aadhaar & PAN No./Form 60 mandatory for availing financial services including Insurance. The Aadhaar & PAN details provided by you would be used for authentication of your identity. In case Aadhaar Number/Pan Number is not provided at the time of application, it is to be submitted within six months from the date of the application failing which it may have an impact on policy status and claim processing.

I understand that the Aadhaar/Virtual ID & PAN details provided by me would be used for authentication of my identity as per applicable law and I hereby give my consent to the company to authenticate my Aadhaar & PAN details & link them with all existing policies I may have or take in future. Yes ☐ No ☐

☐ I am not eligible for Pan Card and in lieu of the same, I am submitting a copy of Form 60.

Proposer : (Mr./Ms./Mrs.)																															
First Name										Middle Name										Last Name											
Date of Birth (DD/MM/YYYY)																					Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F								
Telephone																Mobile No.:															
GSTIN/ UIN (if any) of Policy Holder																					E Mail :										
Aadhaar Number/Virtual ID																					PAN No.										
In case you do not have your Aadhaar Number/Virtual ID please provide Aadhaar Acknowledgment Number below																															
Aadhaar Acknowledgment No.																															
Aadhaar Address:																															
District:																City/Town :															
Pin Code:																State :															
Is your Current Address different from your Aadhaar address, Yes <input type="checkbox"/> No <input type="checkbox"/>																															
If Yes, please provide your Current Address below																															
Current Address:																															
District:																City/Town :															
Pin Code:																State :															
Spouse Name (If applicable)																															
First Name										Middle Name										Last Name											
Mother's Name																															
First Name										Middle Name										Last Name											
Father's Name																															
First Name										Middle Name										Last Name											

Please submit a certified copy of any of the below **Officially Verified Document (OVD)** in any of the following scenarios:

- You are not entitled to be enrolled for Aadhaar and PAN
- The address mentioned in your Aadhaar Card is not your current address

ID Proof Type : Passport ☐ Driving License ☐ Voter's Card ☐ NREGA Job Card ☐

If Others (Any document notified by Central Government), please specify _____

ID Proof No.:

Highest Qualification: Under Matriculate ☐ Matriculate ☐ Graduate ☐ Post-Graduate ☐ Higher ☐

Profession: Salaried ☐ Self Employed ☐ Others ☐ Details _____

Nationality _____ Marital Status _____ Annual Income _____

Do you want to save Planet Earth? The answer to the question is evident but the irony is we all choose wrong option. Here is chance to do right

In case multiple "Yes" options are chosen, the first option would be considered by default.

Go digital with verified & digitally signed documents accessible anytime, anywhere at my fingertips.

Yes ☐

No ☐

I choose e-insurance account to view or download policy details from an Insurance Repository & hereby give my

consent to share my KYC details including Aadhaar No. & PAN with the Insurance Repository.

Yes ☐

No ☐

I choose to have a hard copy as a proof of my policy although it means I am being unprotective to the environment.

Yes ☐

No ☐

PLAN OPTION

Proposed Policy Period : From

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 To

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

VARIANT Essential ☐ Enhance ☐

PLAN Standard ☐ Advanced ☐

2. DETAILS OF THE 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: M <input type="checkbox"/> F <input type="checkbox"/>				Sum insured:				Aadhaar No.											
Mobile Number								Annual Income :													
Insured 2 : Name : Mr./Ms./Mrs.																					
Height	cms	Relationship				Date of Birth				D	D	M	M	Y	Y	Y	Y	Occupation			
Weight	kg	Gender: M <input type="checkbox"/> F <input type="checkbox"/>				Sum insured:				Aadhaar No.											
Mobile Number								Annual Income :													
Insured 3 : Name : Mr./Ms./Mrs.																					
Height	cms	Relationship				Date of Birth				D	D	M	M	Y	Y	Y	Y	Occupation			
Weight	kg	Gender: M <input type="checkbox"/> F <input type="checkbox"/>				Sum insured:				Aadhaar No.											
Mobile Number								Annual Income :													
Insured 4 : Name : Mr./Ms./Mrs.																					
Height	cms	Relationship				Date of Birth				D	D	M	M	Y	Y	Y	Y	Occupation			
Weight	kg	Gender: M <input type="checkbox"/> F <input type="checkbox"/>				Sum insured:				Aadhaar No.											
Mobile Number								Annual Income :													
Insured 5 : Name : Mr./Ms./Mrs.																					
Height	cms	Relationship				Date of Birth				D	D	M	M	Y	Y	Y	Y	Occupation			
Weight	kg	Gender: M <input type="checkbox"/> F <input type="checkbox"/>				Sum insured:				Aadhaar No.											
Mobile Number								Annual Income :													
Insured 6 : Name : Mr./Ms./Mrs.																					
Height	cms	Relationship				Date of Birth				D	D	M	M	Y	Y	Y	Y	Occupation			
Weight	kg	Gender: M <input type="checkbox"/> F <input type="checkbox"/>				Sum insured:				Aadhaar No.											
Mobile Number								Annual Income :													

* Gender Code - M (Male), F(Female)

3. NOMINEE DETAILS

In the event of the death of the proposer 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 Name	Relationship	Address of Nominee

*If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of Appointee

4. EXISTING/PREVIOUS INSURANCE DETAILS*

Is the proposer or the persons proposed, already insured under a plan with Apollo Munich Health Insurance Company Limited or any other insurance company Yes /No ? If YES, please indicate below the Policy/ Application number(s) (Please mention application number incase of pending proposal)

Since when are continuously insured:

Do you want Us to consider these details for continuity* ? Yes ☐ No ☐

Policy No / Application No	Insurer	Period of Insurance		Sum Insured (Rs)	Claims lodged during the preceding years	Status of previous applications (s) if any
		From (DD/MM/YYYY)	To (DD/MM/YYYY)			

* Please note that continuity of benefits shall NOT be considered if the Above question of want of continuity is not replied affirmative, details are not provided and Portability form and relevant supporting documents are not submitted.

5. MEDICAL & LIFESTYLE INFORMATION:

Please read, understand and confirm the details below accurately and truthfully in the space mentioned below, as this would be the ONLY basis of issuance of your policy with us and the subsequent claim admissibility, if any.

ANY MIS-DECLARATION OR NON – DISCLOSURE WILL RENDER YOUR COVERAGE NULL & VOID.

SECTION A:

In respect of any of the persons proposed to be insured, please answer the below mentioned questions individually in Yes(Y)/No (N) along with the details:

		Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
i.	Does your occupation expose you to radiation, corrosive substances, harmful chemicals, mining, asbestos or explosives?.						
ii.	Have you used tobacco in any form in the last one year? E.g Smoked Beedi, cigarette, Cigar, Cheroot, sheesha; used chewing tobacco (Pan/Gutkha); snuff etc						
iii.	Do you consume alcohol, or any narcotic/ habit forming/recreational drug?						
If YES, please indicate the Type, No. of units per day and since when have you been using?							

	Smoke (1 Unit = No. of Beedi, cigarette, Cigar, Cheroot, sheesha or Any other form of tobacco per day)	Pan Masala/ Gutkha (1 Unit = No. of Pouches per day)	Alcohol (1 units = 30 ml of hard liquor ; 150ml of wine; 330ml of beer) per week	Others
Member 1 :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :
Member 2 :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :
Member 3 :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :
Member 4 :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :
Member 5 :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :
Member 6 :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :	TYPE: UNITS : SINCE :

SECTION B : MEDICAL HISTORY

In respect of any of the persons proposed to be insured, please answer the below mentioned questions individually in Yes(Y)/No (N):

PLEASE NOTE THE TERM “CANCER”, WHENEVER USED INCLUDES LEUKEMIA, LYMPHOMA & SARCOMA

	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
a. Have you ever been diagnosed with, operated for, investigated for, underwent chemotherapy/ Radiotherapy or any other form of treatment for any type of Cancer or Tumor or lymphoma or sarcoma?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
b. Has any of your parents, siblings, or first degree relatives ever been diagnosed with any form of cancer? If Yes, also please mention the type of cancer.	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□

c. Have you or any of your family members ever been referred to an oncologist?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
d. Have you been diagnosed with or underwent any investigation in last 5 years for any enlarged gland, enlarged lymph node, any growth, cyst, knot, lump, ulcer, polyp in ANY PART OF THE BODY ?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
e. Have you ever shown any abnormal tumor marker or have shown any abnormality in ultrasound, X-ray, biopsy/histopathology, CT scan, PET scan, Nuclear imaging (ex – MIBG scan or Tc99 scan), MRI, endoscopy, colonoscopy, PAP smear, mammography?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
f. Have you ever suffered from any abnormal or excessive bleeding or bleeding tendencies (Eg, in urine, cough, stool, from gums, vomiting, or during menstrual periods in case of females) or unusual discharge from any body-openings?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
g. Have you ever experienced any difficulty in swallowing, chronic persistent cough, consistent abdominal pain, hoarseness of voice, chest pain or discomfort, constant pain in muscles/bone?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
h. Have you experienced any abnormal weight loss in the past two years (6kg or more) ?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
i. Have you had any blackouts, dizziness, persistent headache, fainting attacks, blurred or double vision, epileptic fits, muscle weakness, abnormal movement or loss of sensation in any part of the body?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
j. Have you ever been diagnosed with Human papillomavirus, Epstein Barr Virus, HIV or sexually transmitted diseases/infections?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
k. Have you ever been diagnosed, treated or investigated or suspected to have– • Any chronic respiratory disease • Any ulcer/ leukoplakia / Aphthous ulcer or any other lesion of the mouth cavity or tongue • Any Endocrinological issue with high or low hormone levels (except Diabetes) • Hepatitis B, Hepatitis C or any chronic liver disease • Gastric/duodenal ulcers, unoperated gall stones or any growth or polyp or ulcer of the digestive tract • Prostate Enlargement • Recurrent fevers and unexplained rashes	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
l. Has any application or proposal for life, health, accident or critical illness including renewal and reinstatement ever been declined, deferred, withdrawn or accepted at special rates or terms by Apollo Munich Health Insurance or any other insurance company.	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□

6. PAYMENT DETAILS:

Mode of payment : Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Electronic Clearing System*(ECS) ☐ NACH ☐ Others _____

Instrument No.	Name of the Premium Payor	Relationship of Payor with proposer	Bank details	Date	Amount (in Rs.)

*If ECS is selected please submit the standing instruction form available at our branches.

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 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 the 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 published prospectuses or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

7. GENERAL EXCLUSIONS (Under the Policy) For more details please refer to the Policy Wordings

For more details on the exclusions and the waiting periods please refer to the Policy wordings before purchasing this Policy.

120 days waiting period from policy commencement for all claim arising due to cancer,

Pre-existing condition for which insured had existing signs & symptoms, and/or was diagnosed, and/ or received consultation, investigation, treatment or admission within anytime months prior to the date on which the policy was issued.

Any Treatment other than Cancer , Items of personal comfort and convenience including but not limited to television (wherever specifically charged for); nuclear weapons/materials, chemical and biological weapons, radiation of any kind; charges for access to telephone and telephone calls (wherever specifically charged for), foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies. vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. Treatments rendered by a Medical Practitioner who is a member of the insured's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by a prescription. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing.

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

- ☐ I hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
- ☐ I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved underwriting policy of the Insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- ☐ I further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- ☐ I declare and further consent to the company, seeking medical information from any hospital who at anytime has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- ☐ I authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory Authority.

Date :

D	D	M	M	Y	Y
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 Time:

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 Place : Signature of the Proposer : _____

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 Proposer :	Signature of the witness :						
Date : <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table> Place :	D	D	M	M	Y	Y	Name of the witness :
D	D	M	M	Y	Y		

9. AGENT'S DECLARATION

I, _____(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)

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Date:

D	D	M	M	Y	Y
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 Place: Signature of Agent: _____

FORM CONTINUED ON THE NEXT PAGE

10. PLEASE PROVIDE DETAILS OF YOUR BANK ACCOUNT (REQUIRED FOR BENEFIT CLAIMS & REFUNDS IF ANY)

[illegible]

Note: The Proposer agrees and undertakes to intimate in writing to Apollo Munich about any change in bank account details.

Proposer/Policy holder's Signature _____ Date:

D	D	M	M	Y	Y
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Would you like your refund (Excess Premium) ☐ By Cheque* or ☐ Credited directly into your bank account. (Tick as applicable)

* Cheque will be issued in the name of the Proposer only.

In case of payment made through credit card the refund amount would be reversed in Credit Card account directly or through cheque.

Please provide the following bank details and a copy of a Cancelled Cheque if you opt for direct credit into your bank account:

(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly)

11. CHECKLIST

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

- i. ID Proof: Passport/ Pan Card/Voter id card/Driving License/ Letter from a recognized public authority/Adhaar card
- ii. Proof of residence: Telephone Bill/ Bank Account Statement/ letter from any recognized public authority/Electricity Bill/ Ration Card
- iii. Age Proof: Passport/PAN card/Driving licence/School or college certificate/Birth Certificate/Government issued ID proof
- iv. Renewal Notice with claim details
- v. Certification of previous insurer for previous claim details
- vi. Photocopies of all previous policies and endorsements

12. FOR OFFICE USE ONLY

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



Application No : _____

Date : _____

Name of Proposer : _____

We acknowledge with thanks the receipt of your application and amount by cash/cheque/Demand Draft/others _____ of amount of Rs. _____.

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. 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 or non-fulfillment of Pre Policy Check-up. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

Signature of the receiver and official seal

We would be happy to assist you. For any help contact us at: E-mail: customerservice@apolloomunichinsurance.com Toll Free: 1800 102 0333