

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		Occupation		Sum Insured*		CI Sum Insured**	
Weight [kg]		Gender*		[D][D][M][M][Y][Y][Y][Y]		[]		[]		[]	
Insured 2. Name: Mr./Ms./Mrs.											
Height [cms]		Relationship		Date of Birth		Occupation		Sum Insured*		CI Sum Insured**	
Weight [kg]		Gender*		[D][D][M][M][Y][Y][Y][Y]		[]		[]		[]	
Insured 3. Name: Mr./Ms./Mrs.											
Height [cms]		Relationship		Date of Birth		Occupation		Sum Insured*		CI Sum Insured**	
Weight [kg]		Gender*		[D][D][M][M][Y][Y][Y][Y]		[]		[]		[]	
Insured 4. Name: Mr./Ms./Mrs.											
Height [cms]		Relationship		Date of Birth		Occupation		Sum Insured*		CI Sum Insured**	
Weight [kg]		Gender*		[D][D][M][M][Y][Y][Y][Y]		[]		[]		[]	
Insured 5. Name: Mr./Ms./Mrs.											
Height [cms]		Relationship		Date of Birth		Occupation		Sum Insured*		CI Sum Insured**	
Weight [kg]		Gender*		[D][D][M][M][Y][Y][Y][Y]		[]		[]		[]	
Insured 6. Name: Mr./Ms./Mrs.											
Height [cms]		Relationship		Date of Birth		Occupation		Sum Insured*		CI Sum Insured**	
Weight [kg]		Gender*		[D][D][M][M][Y][Y][Y][Y]		[]		[]		[]	

* 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 in case 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		

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 pregnant? 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/dioper 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:						

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:

- | | | | | |
|-------------------------------------------------------|---------------------------------------------|------------------------------------------|----------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Television Ad | <input type="checkbox"/> Radio Jingle | <input type="checkbox"/> Hoarding | <input type="checkbox"/> Point of Sale | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> Road Show | <input type="checkbox"/> Exhibition Counter | <input type="checkbox"/> Sponsor Program | <input type="checkbox"/> Brochure | <input type="checkbox"/> Newspaper / Magazine |
| <input type="checkbox"/> 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

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