

This is an application for Insurance. Every Information this application seeks is important. Please read all questions and answer them carefully. You must provide complete and correct information. **Incomplete/incorrect/partially correct information may lead to cancellation of proposal and policy even if it is issued.** It is not obligatory for us to accept any risk or issue policy to anyone. Regulations mandate that the coverage can incept only after we have received the full amount of premium and have explicitly accepted the risk.

Please fill-up this form in CAPITAL LETTERS (Please leave a space after every word) and attach a passport sized photograph of Yourself and each proposed insured person and write the name of the person above the photograph.

1. PROPOSER DETAILS

Proposer : (Mr./Ms./Mrs.)											
First Name				Middle Name				Last Name			
Address :											
City/Town :											
District :											
State :											
Telephone :											
Mobile :											
Pin Code :											
E Mail :											

Nationality : _____ Marital Status : _____ Annual Income : _____

Profession : Salaried Self Employed Others Details _____

ID Proof Type : PAN Passport Driving License Voter's Card Other Details _____

ID Proof No. : _____

2. PLAN & DEDUCTIBLE DETAILS (Please fill sum insured & deductible in table below based on coverage opted.)

Sum Insured options : Rs. 500,000 / Rs. 700,000 / Rs. 10, 00,000 Coverage: Individual Family Floater*

Deductible options : Rs. 100,000 / Rs. 200,000 / Rs. 3 00,000 / Rs. 400,000 / Rs. 500,000 / Rs. 600,000 / Rs. 700,000 / Rs. 1000,000

Proposed Policy Period : From To Proposed Policy Period duration : 1 year 2 year

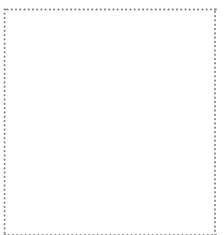
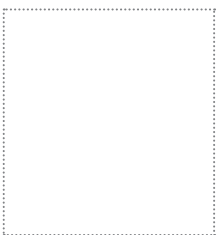
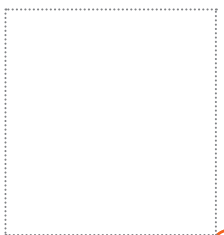
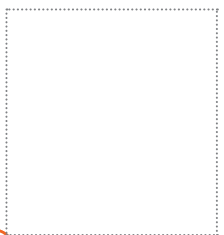
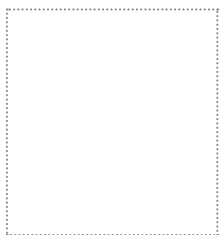
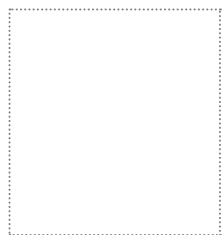
3. PROPOSED INSURED(S) DETAILS

Details of Person Proposed to be Insured

Insured 1 : Name : Mr./Ms./Mrs.											
Height <input type="text"/> cms		Relationship <input type="text"/>		Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Occupation ** <input type="text"/>			
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				Deductible* <input type="text"/>			
Insured 2 : Name : Mr./Ms./Mrs.											
Height <input type="text"/> cms		Relationship <input type="text"/>		Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Occupation ** <input type="text"/>			
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				Deductible* <input type="text"/>			
Insured 3 : Name : Mr./Ms./Mrs.											
Height <input type="text"/> cms		Relationship <input type="text"/>		Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Occupation ** <input type="text"/>			
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				Deductible* <input type="text"/>			
Insured 4 : Name : Mr./Ms./Mrs.											
Height <input type="text"/> cms		Relationship <input type="text"/>		Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Occupation ** <input type="text"/>			
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				Deductible* <input type="text"/>			
Insured 5 : Name : Mr./Ms./Mrs.											
Height <input type="text"/> cms		Relationship <input type="text"/>		Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Occupation ** <input type="text"/>			
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				Deductible* <input type="text"/>			
Insured 6 : Name : Mr./Ms./Mrs.											
Height <input type="text"/> cms		Relationship <input type="text"/>		Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Occupation ** <input type="text"/>			
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				Deductible* <input type="text"/>			

*Family Floater policy will have same basic Sum Insured & Deductible for all members (See brochure for floater policy details) **Designation / Exact nature of duties

Please paste the photographs in sequence (Insured 1, Insured 2, Insured 3, Insured 4, Insured 5 & Insured 6) as specified in section 3 - Proposed insured(s) details

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 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 the Nominee

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

Appointee Name	Relationship	Address of the Appointee

5. 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 you 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
		From						To							
		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		
		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		

* 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.

6. MEDICAL AND LIFE STYLE INFORMATION

Medical History: Please answer the below mentioned questions Yes (Y) or No (N) ONLY:

Section A : Has any of the person proposed to be insured ever suffered from/ are currently suffering from any of the following :		Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
i.	High or low blood pressure, Chest Pain, or any other cardiac disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
ii.	Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
iii.	Ulcer(Stomach/Duodenal), Liver or gall bladder disorder or any other digestive tract disorder?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
iv.	Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/urinary tract disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
v.	Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
vi.	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
vii.	Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
viii.	Arthritis, Spondylosis or any other disorder of the muscle/bone/joint ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
ix.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
x.	HIV/AIDS or sexually transmitted diseases or any immune system disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xi.	Anaemia, Leukaemia, Lymphoma or any other blood/lymphatic system disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xii.	Psychiatric/Mental illnesses or Sleep disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xiii.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder ?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
Section B : Has any of the persons proposed to be insured:							
xiv.	Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xv.	Been under any regular medication (self/ prescribed)?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xvi.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xvii.	Undertaken any surgery or a surgery been advised and have surgery still pending?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xviii.	Suffered from any other disease/illness/accident/injury other than common cold or viral fever?	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>
xix.	Is any of the insured persons pregnant? If yes, please mention the expected date of delivery_____	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>	Y <input type="checkbox"/> /N <input type="checkbox"/>

life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance driven by cultural habits, fashion or the like or any procedures which improve physical appearance. Non allopathic treatment. Conditions for which Hospitalization is not required. Experimental, investigational or unproven treatment devices and pharmacological regimens. Admission primarily for diagnostic purposes not related to illness for which Hospitalization has been done. Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing. Enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products. Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively). Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), sleep-apnoea. Congenital internal or external diseases, defects or anomalies, genetic disorders. Stem celltherapy or surgery, or growth hormone therapy. Venereal disease, sexually transmitted disease or illness; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis. Pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to 1a) in-patient only. Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services. Expenses for organ donor screening, or save as and to the extent provided for in 1e) Organ Donor, the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery). 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 treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), 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. Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured, as per Our underwriting guidelines

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

- I/ We hereby declare, on my behalf and on behalf of all persons proposed to be insured that the above statements, answers and/or particulars given by me 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/ We 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/We declare and 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/ We 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 : Time: :

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 Proposer :

Signature of the witness :

Date : Place :

Name of the witness :

INSURANCE IS THE SUBJECT MATTER OF SOLICITATION

10. 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) :

Date :

Place :

Signature of Agent :

11. CHECKLIST

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

1. ID Proof : Passport/ PAN Card/ Voter ID/ Driving License/ Letter from a recognized public authority
2. Proof of residence : Telephone Bill/ Bank Account Statement/ Letter from any recognized public authority/Electricity Bill/ Ration Card
3. Age Proof : Proof of Age
4. Renewal Notice with claim details
5. Certification of previous insurer for previous claim details
6. 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:

