Maxima
Proposal Form

ApolloMunich HEALTH INSURANCE

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 True to the best of my knowledge.

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 the photograph.

1. PROPOSER DETAILS

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

Nationality : _____ Marital Status : _____ Annual Income : _____

Profession : Salaried ☐ Self Employed ☐ Others ☐ Details _____

ID Proof Type : PAN ☐ Passport ☐ Driving License ☐ Voter's Card ☐ Others ☐

ID Proof No. : | | | | | | | | | | | | | | | |

2. PLAN DETAILS

Plan Name : 1 Member ☐ 2 Members ☐ 2 Adults + upto 2 children ☐

Critical Illness opted : Yes ☐ No ☐

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 D D M M Y Y Y Y Occupation

Weight kg Gender

Insured 2 : Name : Mr./Ms./Mrs.

Height cms Relationship Date of Birth D D M M Y Y Y Y Occupation

Weight kg Gender

Insured 3 : Name : Mr./Ms./Mrs.

Height cms Relationship Date of Birth D D M M Y Y Y Y Occupation

Weight kg Gender

Insured 4 : Name : Mr./Ms./Mrs.

Height cms Relationship Date of Birth D D M M Y Y Y Y Occupation

Weight kg Gender

Please paste the photographs in sequence (Insured 1, Insured 2, Insured 3, Insured 4) as specified in section 3 of proposed to be insured

Insured 1	Insured 2	Insured 3	Insured 4

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

5. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or any of the persons proposed, already insured under a plan with Apollo Munich Health Insurance Company Limited or is a proposal pending for policy issuance? If yes, please indicate below the policy/Application number(s) (Please mention application number incase of pending proposal):

Since when are you continuously insured: D D M M Y Y

(If required kindly attach extra sheet with relevant details, duly signed)

Do you want Apollo Munich Health to consider these details for continuity of your existing Health Insurance Policy ? ☐ Yes ☐ No

Policy No./Application No.	Insurer	From (Date)	To (Date)	Sum Insured	Claim details for last 3 years (if any)
		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		

6. MEDICAL AND LIFE STYLE INFORMATION

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

IMPORTANT: You must answer these questions truthfully.
Not doing so affects your coverage in case of a Claim

Signature of the Proposer

Section A : Have any of the persons 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
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?				
xvii.	Undertaken any surgery or been advised surgery in the last 10 years or have a surgery still pending?				
xviii.	Suffered from any other disease/illness/accident/injury?				
xix.	Been informed that they are Pregnant? If yes, please mention the expected date of delivery				
xx.	Had any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy?				

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				

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Section D : Name, address, qualification and contact details of the family doctor	
Name :	
Address :	
Qualification :	Mobile No. :
Email ID :	

Section E : Does any person proposed to be insured smoke or consume gutkha/ pan masala or alcohol. If yes, please indicate the name and quantity per week.	Alcohol	Smoke	Pan Masala	Others
Insured Person 1 :				
Insured Person 2 :				
Insured Person 3 :				
Insured Person 4 :				

Section F : In respect of any of the persons proposed to be insured:	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4
Has any application for life, health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?				

7. PAYMENT DETAILS

Instrument type : Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others _____

Instrument No.	Name of the Premium Payor	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 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 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 provision of this section shall be punishable with fine which may extend to five hundred rupees.

8. ADDITIONAL INFORMATION

(If there is insufficent space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

9. GENERAL EXCLUSIONS

I have read the below mentioned exclusions carefully. Signature of the proposer _____

The following is an outline of the general exclusions under the policy. For more details on the exclusions and the waiting periods please refer to the policy wordings before purchasing this policy.

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, venereal 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 following an Accident or Illness, experimental, investigational or unproven treatment devices and pharmacological regimens, measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment, convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care, all preventive care, vaccination including inoculation and immunizations, any non allopathic treatment, enteral feedings 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, charges related to a Hospital stay not expressively mentioned as being covered, items of personal comfort and convenience, vitamins and tonics, treatments 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 shares the same residence as an Insured Person or who is 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, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products, any treatment or part of treatment that is not of a reasonable cost, not medically necessary; drugs or treatment which are not supported by a prescription, artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment.

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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 Proposer : Signature of the witness :

Date : Name of the witness :

Place :

Insurance is the subject matter of solicitation

11. 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): | | | | | | | | | | | | | | | | | | | |

Place :

Date : Signature of Agent :

12. CHECKLIST

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

1. ID Proof : Passport/ Pan Card/Voter ID card/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 : 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 :	
Branch Receipt Date	:	Channel Type :	
Business Type	:	Rural/ Social /Other	