

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 or non-fulfillment of pre-policy check-up.

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 :						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

Sum Insured : Rs. 500,000

Deductible : Rs. 100,000 Rs. 200,000 Rs. 300,000 Rs. 400,000 Rs. 500,000

Proposed Policy Period : From To

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"/>		Occupation <input type="text"/>					
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>									
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"/>		Occupation <input type="text"/>					
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>									
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"/>		Occupation <input type="text"/>					
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>									
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"/>		Occupation <input type="text"/>					
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>									
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"/>		Occupation <input type="text"/>					
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>									
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"/>		Occupation <input type="text"/>					
Weight <input type="text"/> kg		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>									

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 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. For all other persons proposed to be insured, the proposer shall be the nominee.

Nominee Name	Relationship	Address of the Nominee

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

Assignee Name	Relationship	Address of the Assignee

5. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or any of the persons proposed, already insured under a plan with Apollo Munich Health Insurance Co. Ltd. or any other insurer or is a proposal pending for Policy issuance? Yes No
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:

D	D	M	M	Y	Y
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 Member ID Employee ID

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 3 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		

6. MEDICAL AND LIFE STYLE INFORMATION

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

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	Insured Person 5	Insured Person 6
i.	Hypertension, chest pain, Ischemic heart disease 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), hepatitis, cirrhosis or any other Digestive or Liver/ Gallbladder 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.	Renal failure, calculus or any other Kidney/Urinary tract or Prostate 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.	Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous 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"/>
vi.	Diabetes, Thyroid 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-benign or malignant, any ulcer/growth/cyst	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 Nose/Ear/Throat/Teeth/ Eye (please mention Diopters)	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 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.	DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/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: Have 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	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 in the last 10 years or is a 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	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"/>
xx.	Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy	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 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 :				
Insured Person 5 :				
Insured Person 6 :				

Section D : Name, address, qualification and contact details of the family doctor, if any:				
Name :				
Qualification :				
Address :				
Pin Code :		Mobile No. :		
Phone 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 :				
Insured Person 5 :				
Insured Person 6 :				

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	Insured Person 5	Insured Person 6
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?	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"/>

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 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 extra sheet duly signed.)

8. 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. 30 days waiting period in the first year and is not applicable in subsequent renewals; 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 intoxicating 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

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-fulfillments of Pre Policy Checkup. 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

INSURANCE IS THE SUBJECT MATTER OF SOLICITATION