

PROPOSAL FORM

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Application No. : \_\_\_\_\_

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). Please attach a passport size color photograph of the person to be insured.**

**1. PLEASE TELL US ABOUT YOURSELF**

My Name(Mr./Ms./Mrs.)															
You will be the policyholder				First Name				Middle Name				Last Name			
My Email id															
This is your user id to log in to our customer wellness portal <a href="https://www.mypollomunich.com">https://www.mypollomunich.com</a> and also allow us to send you important communication that will help manage your health better.															
My Address (we will send your policy and all other important documents here)															
City/Town								District							
State								Pin code							
Date of Birth				D D M M Y Y Y Y				Gender: <input type="checkbox"/> Male / <input type="checkbox"/> Female				My Marital Status			
My Landline No.												My Mobile No.			
Occupation				<input type="checkbox"/> Salaried / <input type="checkbox"/> Self Employed / <input type="checkbox"/> Student / <input type="checkbox"/> Housewife / <input type="checkbox"/> Retired / <input type="checkbox"/> Others:								My Annual Income			
Education				<input type="checkbox"/> Post Grad / <input type="checkbox"/> Grad / <input type="checkbox"/> Diploma / <input type="checkbox"/> 12th Pass / <input type="checkbox"/> 10th Pass / <input type="checkbox"/> Below 10th / <input type="checkbox"/> Others:								Nationality:			
Name of Organization (if working)															
Designation						Nature of Duty									

**TO BE FILLED ONLY IN CASE THE PERSON YOU LIKE TO INSURE IS OTHER THAN YOU.**

Name(Mr./Ms./Mrs.)															
				First Name				Middle Name				Last Name			
Email id															
Address															
City/Town								District							
State								Pin code							
Date of Birth				D D M M Y Y Y Y				Gender: <input type="checkbox"/> Male / <input type="checkbox"/> Female				Marital Status			
Landline No.												Mobile No.			
Occupation				<input type="checkbox"/> Salaried / <input type="checkbox"/> Self Employed / <input type="checkbox"/> Student / <input type="checkbox"/> Housewife / <input type="checkbox"/> Retired / <input type="checkbox"/> Others:								Annual Income			
Education				<input type="checkbox"/> Post Grad / <input type="checkbox"/> Grad / <input type="checkbox"/> Diploma / <input type="checkbox"/> 12th Pass / <input type="checkbox"/> 10th Pass / <input type="checkbox"/> Below 10th / <input type="checkbox"/> Others:								Nationality:			
Name of Organization (if working)															
Designation						Nature of Duty									

**OTHERS (TO BE FILLED FOR PROPOSED PERSON TO BE INSURED)**

Height				Cms.				Weight				Kgs.			
Relationship to Policyholder				<input type="checkbox"/> Self / <input type="checkbox"/> Spouse / <input type="checkbox"/> Mother / <input type="checkbox"/> Father / <input type="checkbox"/> Son / <input type="checkbox"/> Daughter / <input type="checkbox"/> Grand Parents / <input type="checkbox"/> Sibling											

**Did you know that 17 trees are cut for making a tonne a paper?**

I would like to protect my environment and would like to help save paper by authorizing Apollo Munich Health Insurance Company Limited to send all my policy and service related communication to the email id as mentioned in the application form.

**PLEASE PASTE THE PHOTOGRAPH OF THE PERSON PROPOSED TO BE INSURED**

Insured 1

PROPOSAL FORM

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

**2. PLAN DETAILS**

Plan	Silver <input type="checkbox"/> Gold <input type="checkbox"/>
Sum Insured	<input type="checkbox"/> 200,000 / <input type="checkbox"/> 300,000 / <input type="checkbox"/> 500,000 / <input type="checkbox"/> 10,00,000
Do you wish to opt for a 20% Co-Payment	Yes <input type="checkbox"/> No <input type="checkbox"/>

**3. EXISTING/PREVIOUS INSURANCE DETAILS\***

Is the proposer already insured under a health insurance plan 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? \_\_\_\_\_

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 Y <input type="checkbox"/> /N <input type="checkbox"/> (if yes, nature of claim)
		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		

\*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.

**4. MEDICAL AND LIFESTYLE INFORMATION**

This policy not only provides you with coverage against unforeseen health emergencies but also seeks to help you manage health using a wellness program that includes medical tests, doctor visits and expert advice. Hence, it is critical for you to provide an accurate update of your medical history and lifestyle.

**Section A : Medical details**

- 1 Are you currently suffering from diabetes? Y  N   
If yes, please specify whether it is: Type 1 diabetes  Type 2 diabetes  IFG/IGT
- 2 Are you currently suffering from Hypertension? Y  N
- 3 Have you ever suffered from or currently suffering from any of the following conditions? Y  N 
  - a Coma, Unconsciousness, Stroke, Paralysis, Seizures/Epilepsy, Alzheimer's disease, Parkinsonism or any other disorder of nervous system
  - b. Feeble/Absent pulse, Chest pain/Angina, Heart attack, Palpitation, Heart bypass surgery, Heart angioplasty, Heart failure or any other disorder of Heart/Circulation Y  N
  - c. Asthma, Bronchitis, Pneumonia, Tuberculosis or any other disorder of lung Y  N
  - d. Hepatitis B/C, Cirrhosis, Inflammatory bowel disease, Pancreatitis, Alcoholic liver disease or any other disorder of gastro-intestinal tract Y  N
  - e. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint Y  N
  - f. Retinopathy, Cataract, Glaucoma, Sinusitis or any other eye, ear, nose or throat disorder Y  N
  - g. Numbness, Tingling, Painful sensation, Ulcer in the limbs Y  N
  - h. Kidney (Protein or albumin in urine), Kidney and urinary tract stone, Kidney failure, Prostate enlargement or any other disorder of kidney, urinary tract and prostate Y  N
  - i. Hypothyroidism, Hyperthyroidism or any other disorder of endocrine glands Y  N
  - j. Fibroid, Fibroadenoma, Lymphoma, Cancer or any other cyst, tumor, swelling or growth in the body Y  N
  - k. HIV/AIDS, Sexually transmitted disease or any other types of immunodeficiency Y  N 
    - l. Leukemia, Anemia, Thalassemia, Hemophilia or any other blood or bone marrow disorder Y  N
  - m. Depression, Bipolar disorder or any other psychiatric disorder Y  N
  - n. Psoriasis or any other skin disorder Y  N
  - o. Rheumatoid arthritis, Systemic sclerosis or any other auto-immune disorder Y  N
  - p. Congenital (since birth) disorder Y  N
  - q. Any other health condition (other than common cold), not specified above Y  N
- 4 Are you currently pregnant? If yes, please specify (For female proposed insured only) Y  N 
  - a Duration in number of weeks since last period
  - b Suffering from Gestational diabetes or any other pregnancy related complications Y  N

**Quick Help**

**Type 1 Diabetes** also called juvenile or insulin-dependent diabetes indicates a condition in which Beta cell of pancreas are destroyed causing insulin deficiency.

**Type 2 Diabetes** also called maturity onset diabetes indicates a condition which is characterized by either insulin resistance or relative deficiency of insulin secretion usually present at the time of type II diabetes is clinically manifested.

**Impaired Fasting Glucose (IFG)** is impaired level of glucose, a condition under which a person has a plasma glucose value between 110 and 125 mg/dl after overnight fasting.

**Impaired Glucose Tolerance (IGT)** is a condition under which a person, after overnight fasting, has a plasma glucose value between 110 & 125 and 2 hours after 75gm glucose tolerance test, the value is between 140 & 199 mg/dl.

**Gestational diabetes** is a condition in which women without previously diagnosed diabetes exhibit high blood glucose levels during pregnancy.

**Hypertension** is defined as a repeatedly elevated blood pressure where systolic pressure is above 140 and diastolic pressure above 90. (As per JNC 7 guidelines seventh report of the Joint National Committee).

PROPOSAL FORM

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Section B: Lifestyle details	
Which of the following activities do you currently undertake to control and manage your health condition? (Please mention name of the medicines, daily dosage, in case of option B or C)	
a. Diet and lifestyle modification including exercise	Y <input type="checkbox"/> N <input type="checkbox"/>
b. Oral medications	Y <input type="checkbox"/> N <input type="checkbox"/>
c. Insulin	Y <input type="checkbox"/> N <input type="checkbox"/>

Name of the medicine	Dose (mg)	Frequency (Tick)			
		Morning	Afternoon	Evening	Night

Section C: Name and details of Illness/Medicine/Test/ Surgery/Dioper grade (for questions answered as Yes in Section A above)	Exact diagnosis/ Condition	Diagnosis date	Date of last consultation	Treatment in/ outpatient and details of treatment given/advised and currently on	Doctor/Hospital Name and Phone Number

Section D: Name, address, qualification and contact details of the family doctor	
Name:	
Address:	
Qualification:	Email id:
Phone Number:	Mobile:

Section E: Do you smoke or consume gutkha/ pan masala /alcohol? If yes, please indicate the quantity per week.	Alcohol (30ml pegs of hard liquor/ bottles of beer/glasses of wine)	Smoke (No. of Cigarettes/bidi sticks)	Pan Masala/ Gutkha (No. of Pouches)	Others

Section F: In respect of the proposed to be insured:	
Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company? If yes, please specify details including reason. Y <input type="checkbox"/> N <input type="checkbox"/>	

**5. PLEASE TELL US WHO YOU WOULD LIKE TO NOMINATE UNDER THE POLICY**

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 Nominee

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

Appointee Name	Relationship	Address of Appointee

PROPOSAL FORM

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

**6. PAYMENT DETAILS**

Mode of payment:  Cash  Cheque  Debit Card  Credit Card  Electronic Clearing System (ECS)  Others \_\_\_\_\_

Instrument Number	Name of the Premium Payor	Relationship of Payor with Proposer	Bank details	Date	Amount (in Rs.)

Please make an A/c Payee Cheque/DD/Pay Order in favour of 'Apollo Munich Health Insurance Company Limited' only.

**Section 41 of Insurance Act 1938 (Prohibition of rebates):**

- 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.
- Any person making default in complying with the provision of this section shall be punishable with fine which may extend to five hundred rupees.

**7. PLEASE PROVIDE DETAILS OF YOUR BANK ACCOUNT (REQUIRED FOR REFUNDS IF ANY/CLAIMS)**

Would you like your refund (Excess Premium/PPC reimbursement)  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)

Name as in Bank Account:																													
Bank Name:																													
Bank Branch:															Bank Account Number:														
MICR No. :															IFSC Code:														

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

Signature of Proposer: \_\_\_\_\_ Date \_\_\_\_\_

**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 - For more details please refer to the Policy Wordings**

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.

Waiting Periods - 2 years waiting period for the specified illnesses/surgeries. 3 years waiting period for Pre-existing conditions.

Non medical - War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. Any Insured Person committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane. Any Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing.

Medical - Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies. Treatment of Obesity and any weight control program. Plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, Cancer or Burns. Treatment for correction of eye due to refractive error. Circumcisions (unless necessitated by illness or injury and forming part of treatment); Aesthetic or change-of-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

PROPOSAL FORM

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

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 cell therapy 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 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 Organ Donor Benefit, expenses related to organ donor's pre and post hospitalisation. 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. Expense related to pancreatic islet transplantation.

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: \_\_\_\_\_ Signature of the Proposer: \_\_\_\_\_

Place: \_\_\_\_\_

Time: \_\_\_\_\_

**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 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 Proposer: \_\_\_\_\_

Signature of the witness: \_\_\_\_\_

Date: \_\_\_\_\_

Name of the witness: \_\_\_\_\_

Place: \_\_\_\_\_

PROPOSAL FORM

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

**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)

Place:

Date: \_\_\_\_\_ Signature of Agent: \_\_\_\_\_

**11. CHECKLIST**

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

- ID Proof: Passport/PAN Card/Voter Id card/Driving License/Letter from a recognized public authority
- Proof of Residence: Telephone Bill/Bank Account Statement/Letter from any recognized public authority/Electricity Bill/Ration Card
- Age Proof: Passport/Driving License/PAN Card/School/College Certificate/Municipal Birth Certificate/Employment Certificate showing DOB from Govt/Public Sector/Domicile Certificate/Baptism or Marriage Certificate (for Catholics only)
- Renewal Notice with claim details
- Certification of previous insurer for previous claim details
- Photocopies of all previous policies and endorsements

**12. FOR OFFICE USE ONLY**

Apollo Munich Office Code: \_\_\_\_\_ Advisor Code and Name: \_\_\_\_\_

Channel Type: \_\_\_\_\_ Branch Receipt Date: \_\_\_\_\_

Business Type:  Urban/  Rural/  Social

We also offer Travel and Personal Accident Insurance.

E-mail : [customerservice@apollomunichinsurance.com](mailto:customerservice@apollomunichinsurance.com)

TOLL FREE : 1800-102-0333 [www.apollomunichinsurance.com](http://www.apollomunichinsurance.com)

ACKNOWLEDGEMENT

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

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. \_\_\_\_\_.

**Signature of the receiver and official seal**

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. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

**INSURANCE IS THE SUBJECT MATTER OF SOLICITATION**