

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 Other Details _____

ID Proof No. : _____

2. PLAN DETAILS

Plan : Standard Exclusive Premium Type : Individual Floater

Policy Period : 1 Year 2 Year Proposed Policy Period : From

D	D	M	M	Y	Y	Y	Y
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 To

D	D	M	M	Y	Y	Y	Y
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3. PROPOSED INSURED(S) DETAILS

Details of Person Proposed to be Insured

Insured 1 : Name : Mr./Ms./Mrs.																	
Height <input type="text"/>		Relationship <input type="text"/>		Date of Birth <table border="1" style="display: inline-table;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y	Occupation <input type="text"/>			
D	D	M	M	Y	Y	Y	Y										
Weight <input type="text"/>		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				CI Sum Insured** <input type="text"/>									
Insured 2 : Name : Mr./Ms./Mrs.																	
Height <input type="text"/>		Relationship <input type="text"/>		Date of Birth <table border="1" style="display: inline-table;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y	Occupation <input type="text"/>			
D	D	M	M	Y	Y	Y	Y										
Weight <input type="text"/>		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				CI Sum Insured** <input type="text"/>									
Insured 3 : Name : Mr./Ms./Mrs.																	
Height <input type="text"/>		Relationship <input type="text"/>		Date of Birth <table border="1" style="display: inline-table;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y	Occupation <input type="text"/>			
D	D	M	M	Y	Y	Y	Y										
Weight <input type="text"/>		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				CI Sum Insured** <input type="text"/>									
Insured 4 : Name : Mr./Ms./Mrs.																	
Height <input type="text"/>		Relationship <input type="text"/>		Date of Birth <table border="1" style="display: inline-table;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y	Occupation <input type="text"/>			
D	D	M	M	Y	Y	Y	Y										
Weight <input type="text"/>		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				CI Sum Insured** <input type="text"/>									
Insured 5 : Name : Mr./Ms./Mrs.																	
Height <input type="text"/>		Relationship <input type="text"/>		Date of Birth <table border="1" style="display: inline-table;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y	Occupation <input type="text"/>			
D	D	M	M	Y	Y	Y	Y										
Weight <input type="text"/>		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				CI Sum Insured** <input type="text"/>									
Insured 6 : Name : Mr./Ms./Mrs.																	
Height <input type="text"/>		Relationship <input type="text"/>		Date of Birth <table border="1" style="display: inline-table;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y	Occupation <input type="text"/>			
D	D	M	M	Y	Y	Y	Y										
Weight <input type="text"/>		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Sum Insured* <input type="text"/>				CI Sum Insured** <input type="text"/>									

* Family Floater policy will have same Sum Insured for all members (See brochure for floater policy details)

**Critical Illness Sum Insured would be 50% or 100% of the Sum Insured and the same rule is applicable to 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 - 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 Assignee and Relationship with Minor:

Assignee Name	Relationship	Address of the Assignee

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:

D	D	M	M	Y	Y	Y	Y
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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		

* Please note that continuity of benefits shall NOT be considered if the details are not provided.

6. MEDICAL AND LIFE STYLE INFORMATION

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

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

Signature of the Proposer

Section A : Have 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.	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 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 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 other than common cold or 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"/>

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 (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 unless requiring hospitalization, treatment of nasal concha resection, circumcisions unless necessitated by illness or injury and forming part of treatment, 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, Cancer or Burns, 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 (except in case of post-bite treatment), 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 expressly 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.

9. 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. 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/insurer that I or any person proposed to be insured has attended or may attend in future concerning any disease or illness or injury in respect to a particular claim.
- I agree to Apollo Munich Health Insurance Company Limited taking appropriate measures to capture the voice log for all such telephonic transactions carried out by me, in accordance with procedures/regulations.
- I authorize Apollo Munich Health Insurance and associate partners to contact me via e-mail, phone or SMS.

Date :

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