

Individual Personal Accident Proposal Form



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

Application No. : _____

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 if premium is not received by us in full and in time, or is not realised. Please fill-up this form in CAPITAL LETTERS

PROPOSER DETAILS

Proposer : (Mr./Ms./Mrs.)																														
	First Name										Middle name										Last Name									
Address:																														
City/Town											District																			
State																					PIN Code									
Mobile No:											Telephone																			
E- Mail:																														

Nationality : _____

Profession : Salaried Self Employed Others Details _____

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

ID Proof No. :

PLAN DETAILS (Please refer to the brochure for details of benefits under plans Standard & Premium & select the appropriate option below)

Standard Plan Premium Plan

Proposed Policy Period : From To

PROPOSED INSURED(S) DETAILS: Name of the persons proposed to be insured (including proposer)

S No.	Mr./Ms./Mrs.	Name of the person to be insured	Relationship	Gender	Date of Birth	Accidental Death Sum Insured	Temporary Total Disablement Sum Insured
				Male Female			
1							
2							
3							
4							
5							
6							

OCCUPATION & INCOME DETAILS (same order must be maintained as above)

	Occupation & Designation	Organisation	Nature of duties	Annual Income (in Rs.)
Proposed Insured 1				
Proposed Insured 2				
Proposed Insured 3				
Proposed Insured 4				
Proposed Insured 5				
Proposed Insured 6				

NOMINEE DETAILS

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee and his/her receipt of the proceeds would be sufficient discharge to the company. The nominee must be an immediate relative of the Proposer. Nominee for all other persons proposed to be insured shall be the Proposer himself/herself. The following section to be filled for the Proposer

Nominee Name	Relationship	Address of the Nominee

EXISTING INSURANCE DETAILS

Is the proposer or any of the persons proposed, already insured under or proposed for a personal accident insurance policy with Apollo Munich Health or any other insurance company? If yes, please indicate below the Policy/Application number(s) (Please mention application number incase of pending proposal):

Policy No. / Application No.	Insurer	From (Date)						To (Date)						Sum Insured	Claim Details (If any)
		D	D	M	M	Y	Y	D	D	M	M	Y	Y		

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MEDICAL & LIFE STYLE INFORMATION (if your answer to any of the below is 'yes', kindly attach the details in an extra sheet duly signed)

Please answer the below mentioned questions in Yes(Y)/No (N):

In relation to each of the insured persons	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
i. Have you in the past or are you currently suffering from any physical or mental defects/impairment/infirmary/deformity or any condition that may effect your mobility/sight/hearing/speech?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
ii. Have you in the past or are you currently suffering from or have you taken or are you taking treatment for arthritis, gout, paralysis, epilepsy or any other seizure disorder?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
iii. Does your occupation require you to engage in significant manual labor or hazardous activities or requires handling hazardous material or working at height or with high voltage?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□

PAYMENT DETAILS

Instrument type Cash/Cheque/Debit/Credit Card/ Others	Instrument No.	Bank Details	Date						Amount (in Rs)
			D	D	M	M	Y	Y	

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 a separate sheet to this proposal and return it to us.]

GENERAL EXCLUSIONS

Following is an outline of the general exclusions under the policy. Additional exclusions may apply to specific benefits / riders chosen. For more details on the exclusions & waiting periods please refer to the policy wordings before purchasing this policy.

Preexisting conditions & their complications, Self inflicted injury, suicide or attempted suicide, psychiatric or mental disorders, HIV/AIDS, Sexually transmitted diseases, insured persons participation or involvement in naval, military or airforce operations, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing, any breach of law with criminal intent, abuse of intoxicants or hallucinogens including drugs & alcohol, War or any act of war, invasion, act of foreign enemy, war like operations, civil war, public defense, rebellion, revolution, insurrection, military or usurped acts, chemical, radioactive or nuclear contamination, Pregnancy childbirth & it's complications, congenital internal & external disease, treatment rendered by doctor sharing same residence as an insured or is a member of insured's family, non allopathic treatment.

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 terms. 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 doubt, please seek the advice of your insurance advisor.

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You are obliged to inform Apollo Munich Health Insurance Company Ltd without any delay and in writing of all doctors or other members of the medical profession whom you or any of the proposed member have consulted and all changes in your or any other proposed members' state of health or occupation between the filing of this application form and the inception of your insurance cover. If you are in doubt, please seek the advice of your insurance advisor.

DECLARATION & WARRANTY ON BEHALF OF ALL THE 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 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 Ltd. 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 authorise Apollo Munich Health Insurance Company, Ltd. and/or any of its 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 the 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.

Signature of the Proposer:

Signature of the Advisor:

Date:

Place:

Vernacular Declaration

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than the 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:

Date:

Place:

Insurance is the subject matter of solicitation

12. FOR OFFICE USE ONLY

Apollo Munich Health Office Code	:	Advisors Code & Name
Branch Receipt Date	:	Channel Type
Business Type	:	Urban/ Rural/ Social

CHECK LIST (Please check the following documents are attached along with the proposal form)

ID Proof Proof of residence Age proof Income proof

How did you come to know about our company and our products?									
Television Advt.	<input type="checkbox"/>	Radio Jingle	<input type="checkbox"/>	Hoarding	<input type="checkbox"/>	Point of sale	<input type="checkbox"/>	Word of mouth	<input type="checkbox"/>
Road show	<input type="checkbox"/>	Exhibition counter	<input type="checkbox"/>	Sponsor program	<input type="checkbox"/>	Brochure	<input type="checkbox"/>	News paper/Magazine	<input type="checkbox"/>
Others, please specify _____									