Energy

ApolloMunich HEALTH INSURANCE

www.apollomunichinsurance.com

PROPOSAL FORM

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) and attach a passport sized color photograph of Yourself.

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 and also allow us to send you important communication that will help manage your health better.			
GSTIN/ UIN (if any) of Policy Holder			
My Address (we will send your policy and all other important documents here)			
	Landmark		
	City/Town	District	
	State	Pin code	
Date of Birth (D D M M Y Y Y Y)	Gender: ☐ Male / ☐ Female	My Marital Status	
My Landline No.		My Mobile No.	
Occupation	☐ Salaried / ☐ Self Employed / ☐ Student / ☐ Housewife / ☐ Retired / ☐ Others:	My Annual Income	
Education	☐ Post Grad / ☐ Grad / ☐ Diploma / ☐ 12th Pass / ☐ 10th Pass / ☐ Below 10th / ☐ Others:	Nationality:	
Name of Organization (if working)			
Designation		Nature of Duty	

Pan Number*	

☐ I am not eligible for Pan Card and in lieu of the same, I am submitting a copy of Form 60

*Aadhaar No.:	

In case you do not have your Aadhar number, please provide Aadhar Acknowledgement Number

Aadhar Acknowledgement Number

*The Central Government has made Aadhaar and PAN/Form 60 mandatory for availing financial services including Insurance. In case Aadhar Number/Pan Number is not provided at the time of application, it is to be submitted within six months from the date of the application.

I understand that the Aadhar details provided by me would be used for authentication of my identity and I hereby give my consent to the company to authenticate my Aadhar details ☐ Yes ☐ No (In case you are not entitled to be enrolled for Aadhar and PAN then please submit any of the below documents.)

ID Proof Type: Passport ☐ Driving License ☐ Voter's Card ☐ If Other, please specify_____

ID Proof No.:

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			
This is your user id to log in to our customer wellness portal and also allow us to send you important communication that will help manage your health better.			
Address (we will send your policy and all other important documents here)			
	Landmark		
	City/Town	District	
	State	Pin code	
Date of Birth (D D M M Y Y Y Y)	Gender: ☐ Male / ☐ Female	Marital Status	
Landline No.		Mobile No.	
Occupation	☐ Salaried / ☐ Self Employed / ☐ Student / ☐ Housewife / ☐ Retired / ☐ Others:	Annual Income	
Education	☐ Post Grad / ☐ Grad / ☐ Diploma / ☐ 12th Pass / ☐ 10th Pass / ☐ Below 10th / ☐ Others:	Nationality:	
Name of Organization (if working)			
Designation		Nature of Duty	
Aadhaar No.:			

PROPOSAL FORM

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

Height	Cms.	Weight	Kgs.
Relationship to Policyholder	☐ Self / ☐ Spouse / ☐ Mother / ☐ Father / ☐ Son / ☐ Daughter / ☐ Grand Parents / ☐ 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 choose from the below options to go digital for policy & service related communication and thus save trees. In case multiple "Yes" options are chosen, the first option would be considered by default.

I choose to have verified & digitally signed documents that I can access anytime, anywhere at my fingertips. ☐ Yes ☐ No

I choose e-insurance account to view or download policy details from an Insurance Repository. ☐ Yes ☐ No

I choose to have hardcopy of policy documents though this would mean cutting trees for generating those papers. ☐ Yes ☐ No

PLEASE PASTE THE PHOTOGRAPH OF THE PERSON PROPOSED TO BE INSURED

Insured 1

2. PLAN DETAILS

Proposed Policy period:	From D D M M Y Y Y Y to A M P M
Plan	Silver ☐ Gold ☐
By selecting the plan above I hereby provide my consent to Apollo Munich to access the diagnostic reports submitted by me for availing Wellness and HbA1C Checkup benefits	
Sum Insured	☐ 200,000 ☐ 300,000 ☐ 500,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000
Do you wish to opt for a 20% Co-Payment	Yes ☐ No ☐

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 incase 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
		From	To		Y ☐ /N ☐ (If yes, nature of claim)
		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.

PROPOSAL FORM

Section A : Medical details

1	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 ☐/N ☐
2	**Are you currently suffering from diabetes?** If Yes, please specify whether it is Type 1 diabetes ☐ Type 2 diabetes ☐ IFG/IGT ☐	Y ☐/N ☐
	Please specify	
3	**Are you currently suffering from Hypertension?**	Y ☐/N ☐
4	**Have you ever suffered from or currently suffering from any of the following condition?**	Y ☐/N ☐
a)	Coma, Unconsciousness, Stroke, Paralysis, Seizures/Epilepsy, Alzheimer's disease, Parkinsonism or any other disorder of nervous system	Y ☐/N ☐
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, Thallasemia, 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)	Rhematoid 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 ☐
3	**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 ☐

Type 2 Diabetes also called maturity onset diabetes indicates a condition which is characterized by either insulin resistance or relative deficiency of insulin **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. 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).

Section B: Lifestyle details

Please specify which of the following activities currently undertaken by you to control and manage your health condition? (Please mention name of the medicines, daily dosage, in case if option b or c has been ticked.)

a. Diet and lifestyle modification including exercise Y ☐ N ☐

b. Oral medications Y ☐ N ☐

c. Insulin Y ☐ N ☐

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

PROPOSAL FORM

Section C: Name and details of Illness/Medicine/Test/ Surgery/Diopter 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

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

6. PAYMENT DETAILS

Mode of payment: ☐ Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Electronic Clearing System (ECS))# ☐ NACH ☐ Others _____

#If ECS is selected please submit the standing instruction form available at our branches

Cheque 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.

I want to opt for Auto Renewal Facility. [This facility will be enabled only if ECS form is submitted] ☐ Yes ☐ No

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (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 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 the 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 published prospectuses or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

PROPOSAL FORM

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:									IFSC Code:															
MICR No. :																								

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

Signature Proposer: _____ Date_____

Additional Informat

(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 - 30 days waiting period in the first year and is not applicable in subsequent renewals. 2 years waiting period for the specified illnesses/ surgeries. 2 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 (examples of the treatments: fametolaser, lasik). 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 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, cochlear implant , 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). Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), sleep-apnoea.

Congenital external diseases, defects or anomalies,. 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-Organ Donor, the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery). 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 lifetime exclusion(s) not exceeding 48 months 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.
- ☐ / 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 further 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: _____

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)* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

PROPOSAL FORM

- 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

13. PERFORATED ACKNOWLEDGEMENT

Application Number _____

Name of Proposer _____ We acknowledge with thanks the receipt of your application and amount by cash/ cheque/ demand draft/ others _____ of amount Rs. _____.

Signature and Seal:

Date:

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 15 days.

Apollo Munich Health Insurance Co. Ltd. • Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • Reg. Off. Apollo Hospitals Complex, 8-2-293/82/J III/DH/900 Jubilee Hills, Hyderabad, Telangana - 500033, India. • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDAI Registration Number - 131 • Corporate Identity Number: U66030TG2006PLC051760 • **UIN:** APOHLIPI8126V031718 • **CIN:** U66030TG2006PLC051760 • **URN:** AM/HLT/0007/A/092017