

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 and attach a passport sized photograph for Yourself and each person proposed to be insured and write the name of the person above the photograph.**

1. PROPOSER DETAILS

Proposer : (Mr./Ms./Mrs.)															
		First Name				Middle Name				Last Name					
Address :															
District :						State :									
Pin Code :						Mobile :				City/Town :					
Telephone :						E Mail :									

Nationality : _____ Marital Status : _____ Annual Income : _____

Profession : Salaried Self Employed Others Details _____

ID Proof Type : PAN Passport Driving License Voter's Card If others, please specify _____

ID Proof No. : Aadhaar No:

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

2. PLAN DETAILS

Plan : Standard Exclusive Premium Coverage : Individual Floater

Proposed Policy Period: From To Tenure: 1 year 2 year

3. PROPOSED INSURED(S) DETAILS

Insured 1 : Name : Mr./Ms./Mrs.												Date of Birth			
Height		cms		Relationship				Mobile No.				Occupation :			
Weight		kg		Gender*:		Male <input type="checkbox"/> Female <input type="checkbox"/>		Aadhaar No.				Basic sum insured**:			
Critical Illness Rider Sum Insured*** :								Critical Advantage Rider Sum Insured (USD)# :							
Insured 2 : Name : Mr./Ms./Mrs.												Date of Birth			
Height		cms		Relationship				Mobile No.				Occupation :			
Weight		kg		Gender*:		Male <input type="checkbox"/> Female <input type="checkbox"/>		Aadhaar No.				Basic sum insured**:			
Critical Illness Rider Sum Insured*** :								Critical Advantage Rider Sum Insured (USD)# :							
Insured 3 : Name : Mr./Ms./Mrs.												Date of Birth			
Height		cms		Relationship				Mobile No.				Occupation :			
Weight		kg		Gender*:		Male <input type="checkbox"/> Female <input type="checkbox"/>		Aadhaar No.				Basic sum insured**:			
Critical Illness Rider Sum Insured*** :								Critical Advantage Rider Sum Insured (USD)# :							
Insured 4 : Name : Mr./Ms./Mrs.												Date of Birth			
Height		cms		Relationship				Mobile No.				Occupation :			
Weight		kg		Gender*:		Male <input type="checkbox"/> Female <input type="checkbox"/>		Aadhaar No.				Basic sum insured**:			
Critical Illness Rider Sum Insured*** :								Critical Advantage Rider Sum Insured (USD)# :							
Insured 5 : Name : Mr./Ms./Mrs.												Date of Birth			
Height		cms		Relationship				Mobile No.				Occupation :			
Weight		kg		Gender*:		Male <input type="checkbox"/> Female <input type="checkbox"/>		Aadhaar No.				Basic sum insured**:			
Critical Illness Rider Sum Insured*** :								Critical Advantage Rider Sum Insured (USD)# :							
Insured 6 : Name : Mr./Ms./Mrs.												Date of Birth			
Height		cms		Relationship				Mobile No.				Occupation :			
Weight		kg		Gender*:		Male <input type="checkbox"/> Female <input type="checkbox"/>		Aadhaar No.				Basic sum insured**:			
Critical Illness Rider Sum Insured*** :								Critical Advantage Rider Sum Insured (USD)# :							

* Gender Code M (Male), F(Female) ** 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 subject to a minimum of Rs 100,000 and maximum of Rs 10 Lacs and the same rule is applicable to all members. # Critical advantage rider offered on individual sum insured basis. Rider can be opted by adult dependent only if primary insured also opts for the same. In case of dependent children and dependent parents rider can be opted on all or none basis.

PHOTOGRAPHS

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 Appointee 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:

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		
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="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.

6. MEDICAL AND LIFE STYLE INFORMATION

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

Section A : 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, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
Section B: Has 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.	High or low blood pressure, Chest Pain, or any other cardiac disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
ii.	Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
iii.	Ulcer(Stomach/Duodenal),liver or gall bladder disorder or any other digestive tract disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
iv.	Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/urinary tract disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
v.	Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
vi.	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
vii.	Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
viii.	Arthritis, Spondylosis or any other disorder of the muscle/bone/joint	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
ix.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) ?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
x.	HIV/AIDS or sexually transmitted diseases or any immune system disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
xi.	Anaemia, Leukaemia, Lymphoma or any other blood/lymphatic system disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
xii.	Psychiatric/Mental illnesses or sleep disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
xiii.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
xiv.	Any other illness or injury not mentioned above (other than common cold)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
Section C: Has any of the persons proposed to be insured:							
xv.	Been addicted to alcohol, narcotics, and habit forming drugs or been under detoxication therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O
xvi.	Been under any regular medication (self/ prescribed)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O

xvii.	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□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
xviii.	Undertaken any surgery or a surgery been advised and have surgery still pending?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□
xix.	Suffered from any other disease/illness/accident/injury other than common cold or viral fever?						
xx.	Is any of the insured pregnant? If yes please mention the expected date of delivery. Any complication during current or earlier pregnancy?	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□	Y□/N□

Section D: Name and details of Illness/ Medicine/Test/ Surgery/ Diopter grade (for questions answered as Yes in Section A & B above)	Exact Diagnosis	Diagnosis Date	Date of last consultation	Treatment In/Outpatient and details of treatment given	Doctor/Hospital Name & Phone No.
Insured Person 1 :					
Insured Person 2 :					
Insured Person 3 :					
Insured Person 4 :					
Insured Person 5 :					
Insured Person 6 :					

Section E: Name, address, qualification and contact details of the family doctor, if any											
Name :											
Qualification :											
Address :											
Pin Code :						Mob. No. :					
Phone No. :						Email ID :					

Section F : : 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 (30ml pegs of hard liquor/ bottles of beer/ glass of wines)	Smoke (No. of Cigarette/ bidi sticks)	Pan Masala/ Gutkha (No. of Pouches)	Others
Insured Person 1 :				
Insured Person 2 :				
Insured Person 3 :				
Insured Person 4 :				
Insured Person 5 :				
Insured Person 6 :				

7. PAYMENT DETAILS

Mode of Payment:: Cash / Cheque / Debit Card / Credit Card / Electronic Clearing System*/ Others _____

Instrument No.	Name of the Premium Payor	Relationship of Payor with Proposer	Bank details	Date	Amount (in Rs.)

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

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

Section 41 of Insurance Act1938 (Prohibition of rebates):

- 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.
- 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.

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 (UNDER THE POLICY) 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. 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 in professional or semi-professional nature.

Medical - Treatment of illness or injury as a consequence of the use of alcohol, tobacco, narcotic or psychotropic substances.; Prosthetic and other devices which are self-detachable/removable without surgery involving anaesthesia; Treatment availed outside India. Treatment at a healthcare facility that is not a Hospital; Treatment of obesity and any weight control program. ;Treatment for correction of eye sight due to refractive error;Cosmetic, aesthetic and re-shaping treatments and surgeries; Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns. 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; Save as and to the extent provided for under 1 h.) Non allopathic treatment; Conditions for which treatment could have been done on an outpatient basis without any Hospitalization; Charges related to peritoneal dialysis, including supplies; Admission primarily for administration of monoclonal antibodies or IV immunoglobulin infusion; Experimental, investigational or unproven treatment devices and pharmacological regimens.; Admission primarily for diagnostic and evaluation purposes only ;Any diagnostic expenses which are not related and not incidental to any illness which is not covered in this Policy; Convalescence, rest cure, sanatorium treatment, rehabilitation measures, , respite care, long-term nursing care or custodial care. safe confinement, de-addiction, general debility or exhaustion ("run-down condition") Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment) ; Admission primarily for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements ; Save as and to the extent provided in 3 c.) 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.; Parkinson and Alzheimer's disease, sleep-apnoea. Congenital 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. Save as and to the extent provided for under 3a.) 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 a claim under 1a) for In-patient Treatment only. Treatment for Sterility, infertility (primary or secondary) assisted conception or other related conditions and complications arising out of the same. Birth control, and similar procedures including complications arising out of the same. Expenses incurred by the insured on organ donation; Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle ;Save as and to the extent provided for under 3b), dental treatment and surgery of any kind, unless requiring Hospitalisation. mutation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. Any non medical expenses mentioned in Annexure I. Any Medical Expenses incurred using facility of any Medical Practitioners or institution that We have told You (in writing) is not to be used at the time of renewal or at any specific time during the policy period. 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 Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. 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. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. Drugs or treatments which are not supported by a prescription.

Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured.

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.
- I/We have understood the purpose of Aadhaar authentication and hereby state that I/We have no objection in providing my Aadhaar details.

Date : Time: 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 : Name of the witness :

Place :

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 :

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
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 :

