MY PRODUCT DETAILS (To be filled with assistance of Agent)

OPTIMA RESTORE

Description- A unique inpatient health insurance product providing base coverage for medical treatment due to illness or accident with unique restore and multiplier benefit. Basic sum insured is restored without any charge if you exhaust your sum insured in the middle of the year. Also in case you have a claim-free year, multiplier benefit increases the insurance cover by 50% the first year and doubles it the year after, at no extra charge

Application No.	Plan Type	Plan Tenure (1 year/ 2 year)	Premium
OR ____________	☐ Individual ☐ Floater	☐ 1 year ☐ 2 year	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Sum Insured *						
Critical Advantage Sum Insured (USD)#						

*Incase of Floater Option, Please mention Sum Insured for member 1 only.

Critical Advantage rider will be offered if base policy Sum Insured is Rs. 10 lacs & above.

GENERAL EXCLUSIONS

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.

All treatments within the first 30 days of cover except any accidental injury, 2 year waiting period for specified illness/ conditions, Pre- existing waiting period for 36 months, War or any act of war, invasion, act of foreign enemy, war like operations, nuclear weapons/materials radiation of any kind, committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted 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 external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy, venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus), sterility / infertility treatment of any type, 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, 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, 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, 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.

Please specify Preferred Risk Start Date* (if any) in space provided D D M M Y Y Y Y

*Will be subject to policy terms and conditions and the acceptance norms specific to this product.

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 are true andcomplete 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 further consent to the company. seeking medical information from any hospital I 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 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**

Signature of Proposer: ____________ 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)

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: ____________ Date: ________ Place: ____________

Name of the witness: ____________

Signature of witness: ____________ Date: ________ Place: ____________

We would be happy to assist you. For any help contact us at: Email: customerservice@apollomunichinsurance.com Toll Free: 1800 102 0333

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, Jubilee Hills, Hyderabad-500033, Telangana • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDAI Reg. No.: - 131 • CIN: U66030AP2006PLC051760

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