Optima Cash Platinum Plan
Proposal Form

ApolloMunich HEALTH INSURANCE

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

Application No. : ____________________

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. You are obliged to inform Apollo Munich Health Insurance Company Limited without any delay & in writing of all doctors or other members of medical profession whom you or any of the proposed member/s have consulted & all changes in your or any other proposed members' state of health between the filing of this application form & inception of your insurance cover. 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. Please fill-up this form in CAPITAL LETTERS.

1. PROPOSER DETAILS

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

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

2. PLAN DETAILS

Daily Cash Amount (Rs) 1,000 ☐ 2,000 ☐ 3,000 ☐

Number of Days 90 days

Tenure 1 Year ☐ 2 Years ☐

Proposed Policy Period : From D D M M Y Y Y Y To D D M M Y Y Y Y

3. PROPOSED INSURED(S) DETAILS

Insured 1.Name: (Mr./Ms./Mrs.)					
Relationship		Gender	M F	Date of Birth	D D M M Y Y Y Y
Insured 2.Name: (Mr./Ms./Mrs.)					
Relationship		Gender	M F	Date of Birth	D D M M Y Y Y Y
Insured 3.Name: (Mr./Ms./Mrs.)					
Relationship		Gender	M F	Date of Birth	D D M M Y Y Y Y
Insured 4.Name: (Mr./Ms./Mrs.)					
Relationship		Gender	M F	Date of Birth	D D M M Y Y Y Y
Insured 5.Name: (Mr./Ms./Mrs.)					
Relationship		Gender	M F	Date of Birth	D D M M Y Y Y Y
Insured 6.Name: (Mr./Ms./Mrs.)					
Relationship		Gender	M F	Date of Birth	D D M M Y Y Y Y

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. For all other persons proposed to be insured, the Proposer shall be the nominee.

Nominee Name	Relationship	Address of the Nominee

5. MEDICAL QUESTIONNAIRE:

Important: You must answer this question truthfully, not doing so affects your coverage in case of a claim.

Signature of the Proposer

Please answer the below mentioned question in Yes (Y)/No (N):	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
Have any of the person(s) proposed to be insured in the last 5 years suffered from/currently suffering from/ or been investigated for any diseases, ailments, medical conditions or illness, accident, injury?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

If yes, please provide following details below: (In case of more than one insured member please provide the additional information in the space below.)

Name of Insured Person:	(a) Name of illness/ injury suffering from or suffered or investigated in the past.
	(b) Treatment/medication received/receiving.
	(c) Details of the treating doctor (Name, Hospital / clinic, Contact No.).

Please answer the below mentioned questions in Yes(Y)/No (N):	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
In respect of any of the persons proposed to be insured, has any application for life, health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

6. ADDITIONAL INFORMATION

7. PAYMENT DETAILS

Instrument type : Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others ____________

Instrument No.	Name of the Premium Payor	Bank Details	Date	Amount (in Rs.)

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 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 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.

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

8. GENERAL EXCLUSIONS I have carefully read and understood the below mentioned exclusions. Signature of the proposer

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 period for the first 30 days except if the insured suffers an accident; 2 year waiting period for specified conditions; Any Pre-existing condition; War or any act of war, invasion, act of foreign enemy, war like operations, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/ materials, chemical and biological weapons, radiation of any kind; any epidemics recognised by WHO; any breach of the law with criminal intent or arising out of or as a result of any act of self-destruction or self inflicted injury, attempted suicide or suicide, participation or involvement in naval, military or air force operation, racing, diving, 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, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies; treatment of obesity or morbid obesity and any weight control program; Psychiatric; mental disorders; Parkinson and Alzheimer's disease; general debility or exhaustion ("run-down condition"); internal or external congenital diseases, defects or anomalies, genetic disorders; stem cell implantation 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 (when associated with HIV infections); 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, 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; Dental treatment and surgery of any kind, unless requiring Hospitalisation; Circumcisions unless required as a part of treatment of an illness or injury; laser treatment for correction of eye due to refractive error; aesthetic or change-of-life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance or carried out in childhood or at any other times driven by cultural habits, fashion or the like or any procedures which improve physical appearance; 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 or cancer; Experimental, investigational or unproven treatment devices and pharmacological regimens; Any procedure primarily for diagnostic or preventive purposes, which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness; Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care; Any non allopathic treatment; Any treatment or part of a treatment that is not medically necessary.

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 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 Limited. 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 Limited.
- ☐ I further consent and authorize Apollo Munich Health Insurance Company Limited and/or any of their 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 future concerning any disease or illness or injury.
- ☐ 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: Signature of the Proposer

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:

Insurance is the subject matter of solicitation

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

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:

Signature of Agent:

Place:

11. FOR OFFICE USE ONLY

Apollo Munich Health Office Code:	Advisor Code and Name:
Branch receipt date:	Channel Type:
Business Type: Urban/ Rural/ Social	

AMHI/PR/H/0013/0042B/102010/P