Proposal Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

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)

1. PLEASE TELL US ABOUT YOURSELF

My name : (Mr./Ms./Mrs.)			
You will be the policyholder of this policy	First Name	Middle Name	Last Name
My Address : (*We will send your policy and all other important documents here*)			
City/Town :		District :	
State :			Pin Code :
My Marital Status :	My Nationality :		My Annual Income :

My Mobile No. ☐☐☐☐☐☐☐☐☐☐

My landline No. with STD Code) ☐☐☐☐☐☐☐☐☐☐☐

My Email id [This is your user id to log in to our customer wellness portal] _____

Did you know that 17 trees are cut for making a tonne of paper?

GO-GREEN

☐ 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. PLEASE TELL US MORE ABOUT MEMBERS YOU WOULD LIKE TO INSURE IN THIS POLICY (Include your details if you would also like to be insured)

Member 1:

Name : (Mr./Ms./Mrs.)

Photograph

DOB: D D M M Y Y Y Y ☐☐☐☐☐☐☐☐ Gender: ☐ M / ☐ F Height: cms _____ Weight: kgs _____

Relationship to Policy Holder: Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others ☐

Education: Post Grad ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th ☐ Others _____

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐

Others : _____ Annual Income: _____

Name of the Organization : _____

Designation: _____ Nature of duty: _____

Product opted : _____

Member 2:

Name : (Mr./Ms./Mrs.)

Photograph

DOB: D D M M Y Y Y Y ☐☐☐☐☐☐☐☐ Gender: ☐ M / ☐ F Height: cms _____ Weight: kgs _____

Relationship to Policy Holder: Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others ☐

Education: Post Grad ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th ☐ Others _____

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐

Others : _____ Annual Income: _____

Name of the Organization : _____

Designation: _____ Nature of duty: _____

Product opted : _____

Member 3:

Name : (Mr./Ms./Mrs.)

Photograph

DOB: D D M M Y Y Y Y Gender: ☐ M / ☐ F Height: cms Weight: kgs

Relationship to Policy Holder: Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others ☐

Education: Post Grad ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th ☐ Others _____

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐

Others : _____ Annual Income: _____

Name of the Organization : _____

Designation: _____ Nature of duty: _____

Product opted : _____

Member 4:

Name : (Mr./Ms./Mrs.)

Photograph

DOB: D D M M Y Y Y Y Gender: ☐ M / ☐ F Height: cms Weight: kgs

Relationship to Policy Holder: Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others ☐

Education: Post Grad ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th ☐ Others _____

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐

Others : _____ Annual Income: _____

Name of the Organization : _____

Designation: _____ Nature of duty: _____

Product opted : _____

Member 5:

Name : (Mr./Ms./Mrs.)

Photograph

DOB: D D M M Y Y Y Y Gender: ☐ M / ☐ F Height: cms Weight: kgs

Relationship to Policy Holder: Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others ☐

Education: Post Grad ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th ☐ Others _____

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐

Others : _____ Annual Income: _____

Name of the Organization : _____

Designation: _____ Nature of duty: _____

Product opted : _____

Member 6:

Name : (Mr./Ms./Mrs.)

Photograph

DOB: D D M M Y Y Y Y Gender: ☐ M / ☐ F Height: cms Weight: kgs

Relationship to Policy Holder: Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others ☐

Education: Post Grad ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th ☐ Others _____

Occupation: Salaried ☐ Self Employed ☐ Professional ☐ Student ☐ Housewife ☐ Retired ☐

Others : _____ Annual Income: _____

Name of the Organization : _____

Designation: _____ Nature of duty: _____

Product opted : _____

3. 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: D D M M Y Y Y Y

Do you want Us to consider these details for continuity*? ☐ Yes ☐ No

Policy No./ Application No.	Previous Insurer	Period of Insurance		Sum Insured (Rs.)	Claims lodged during the preceding years	Status of Previous application(s) if any
		From	To			

D D M M Y Y D D M M Y Y

* Please note that continuity of benefits shall NOT be considered if the details are not provided.

4. PLEASE PROVIDE US WITH INFORMATION ON MEDICAL HISTORY AND LIFE STYLE OF ALL MEMBERS INCLUDED IN THIS POLICY

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:	Member 1	Member 2	Member 3	Member 4	Member 5	Member 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?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
Section B: Have any of the person proposed to be insured ever suffered from/ are currently suffering from any of the following.						
I. High or low blood pressure, Chest Pain or any heart disease	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
II. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
III. Ulcer(Stomach/Duodenal),liver or gall bladder disorder or any other digestive tract disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
IV. Kidney Failure, Stone in kidney and urinary tract, Prostate disorder or any other kidney/urinary tract disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
V. Stroke, Epilepsy (fits), Paralysis or other nervous system (Brain, spinal cord, etc) disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
VI. Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
VII. Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
VIII. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
IX. Diseases of the Ear/Nose/Throat/Teeth/Eye (please mention Dioptres in case of refractory error)?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
X. HIV/AIDS or sexually transmitted diseases or any immune system disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
XI. Anemia , Leukemia, Lymphoma or any other blood/lymphatic system disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
XII. Psychiatric/Mental illnesses or sleep disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
XIII. Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
XIV. Any other illness or injury not mentioned above (other than common cold)?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
Section C: Have any of the persons proposed to be insured:						
I. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
II. Been under any regular medication (self/ prescribed)?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
III. 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 ☐
IV. 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 ☐
V. 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 & details of Illness/ Medicine/Test/Surgery/Diopter grade (for questions answered as Yes in Section B & C above) attach additional sheet, if required.					
Insured Name	Exact diagnosis	Diagnosis date	Date of last consultation	Treatment in/outpatient	Doctor/Hospital Name & Phone No.

Section E: Name, address, qualification and contact details of the family doctor, if any			
Name :			
Address :			
Qualification :		Phone/Mobile :	
Email :			

Section F: Does any person proposed to be insured consumes alcohol, 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
Member 1 :				
Member 2 :				
Member 3 :				
Member 4 :				
Member 5 :				
Member 6 :				

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

5. PLEASE TELL US WHO YOU WOULD LIKE TO NOMINATE

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

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

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

Please make a A/c Payee 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.

7. 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 : _____

Signature of Agent: _____ Date: _____ Place: _____

8. 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 : Proof of Age
4. Renewal Notice with claim details
5. Certification of previous insurer for previous claim details
6. Photocopies of all previous policies and endorsements

9. FOR OFFICE USE ONLY

Apollo Munich Health Office Code : _____

Advisors Code & Name : _____

Branch Receipt Date : _____

Channel Type : _____

Business Type : Urban / Rural / Social

NEFT details

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account

Please select any one of the below options

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy:

- ☐ Bank account details as mentioned on the cheque* being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.
- ☐ I do not have any existing bank account. I agree to open a bank account and provide my bank account details to the Company for electronic fund transfer as mode of payment. I shall provide these details before renewal of my insurance policy or before any payment becomes due in relation to my insurance policy (whichever is earlier). I understand that as per regulatory requirement, Company shall process any payment in relation to my insurance policy only through electronic fund transfer after receipt of aforesaid pending bank details from me.
- ☐ Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the Company for electronic fund transfer as mode of payment. (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly)

Particulars of Bank Account:

Name as in Bank Account:																							
Bank Name:																							
Bank Branch:								Bank Account Number:															
MICR No. :										IFSC Code:													

I agree and undertake to intimate in writing to Apollo Munich about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Date : D D M M Y Y

Proposer/Policy holder's Signature ☑

DISCLAIMER: APOLLO MUNICH shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder. Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. Apollo Munich shall be indemnified against any loss/damage/claims caused to Apollo Munich in carrying out your aforesaid NEFT instructions.

Instructions:

- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFS Code, which is applicable for NEFT only. (a number allotted to each participating banks branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required
- NEFT Form needs to be complete in all respect.

*** in case the premium payment cheque does not have all the details required for electronic fund transfer, please fill the above table**

Acknowledgement

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Application No : _____ Date : _____

Name of Proposer : _____

We acknowledge with thanks the receipt of your application and amount by cash/cheque/Demand Draft/others _____ of amount of Rs. _____.

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 30 days.

Signature of the receiver and official seal

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

EASY HEALTH

Description- A inpatient health insurance product providing base coverage for medical treatment due to illness or accident with optional Critical Illnesses cover.

Application No.	Plan Variant	Rider (if Opted)	Plan Type	Plan Tenure (1 year/ 2 year)	Premium
EH _____	☐ Standard ☐ Exclusive ☐ Premium	☐ Critical Illness	☐ Individual ☐ Floater	☐ 1 year ☐ 2 year	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Sum Insured *						
Critical Illness Sum Insured #	☐ 50%	☐ 50%	☐ 50%	☐ 50%	☐ 50%	☐ 50%
	☐ 100%	☐ 100%	☐ 100%	☐ 100%	☐ 100%	☐ 100%

Easy health critical Illness sum insured would be 50% or 100% of the In-Patient Sum Insured and the same rule is applicable to all members.

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

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 internal or 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 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 further consent to the company. seeking medical information from any hospital Iwho 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.

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: _____

AMHI/PR/H/0022/0084/032082/P

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 *						

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

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 internal or 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 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 further consent to the company. seeking medical information from any hospital Iwho 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.

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: _____

Apollo Munich Health Insurance Co. Ltd • Reg Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad -500033 AP. • Corp. Off. 10th Floor, Tower B,Building No 10, DLF Cybercity, DLF City Phase II, Gurgaon-122002, Haryana • Insurance is the subject matter of solicitation. • For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale. • IRDA Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

AMHI/PR/H/0022/0084/032082/P

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

OPTIMA PLUS

Description-Optima Plus is India's only Top-up Health plan with an option of converting into a full-fledged nil deductible Health Insurance plan when you retire. Firstly, you pay a nominal premium for the top-up that helps you cover higher medical spends. Secondly, when you retire, it gives you an option to opt for a regular plan with nil deductible.

Application No.	Plan Tenure (1 year/ 2 year)	Premium
OP _____	☐ 1 year ☐ 2 year	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Sum Insured						
Deductible						

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 48 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 internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy; sleep apnoea; venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus)' sterility / infertility treatment of any type; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; 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; dental treatment unless requiring hospitalization; treatment of nasal concha resection, 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, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment; 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; enteral feedings 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; charges related to a Hospital stay not expressively mentioned as being covered, 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 or who is a member of an Insured Person's family; the 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; any treatment or part of treatment that is not of a reasonable cost, not medically necessary; drugs or treatment which are not supported by a prescription; artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment.

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

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Name of the witness: _____

Signature of witness: _____ Date: _____ Place: _____

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AMHI/PR/H/0022/0084/032082/P

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

MAXIMA

Description- An inpatient + outpatient health insurance product providing base coverage for medical treatment due to illness or accident along with unique out-patient cover and optional Critical Illnesses cover.

Application No.	Plan Variant	Rider (if Opted)	Premium
MA _____	☐ 1 Member ☐ 1 Members ☐ 2 Adults+ 2 children	☐ Critical Illness	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4
Sum Insured *				
Critical Illness Sum insured #				

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

Critical Illness sum insured would be 100% of the In-Patient Sum Insured and the same rule is applicable to all members.

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 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 internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy, sleep apnoea, venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus), sterility / infertility treatment of any type, pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy, treatment and supplies for analysis and adjustments of spinal subluxation, treatment of nasal concha resection, circumcisions unless medically necessary, 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 or Illness, experimental, investigational or unproven treatment devices and pharmacological regimens, measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment, 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, any non allopathic treatment, enteral feedings 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, charges related to a Hospital stay not expressively mentioned as being covered, 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 or who is a member of an Insured Person's family, the 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.

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

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Signature of Proposer: _____ Date: _____ Time: _____ Place: _____

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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: E-mail : customerservice@apollomunichinsurance.com Toll Free : 1800-102-0333

Apollo Munich Health Insurance Co. Ltd • Reg Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad -500033 AP. • Corp. Off. 10th Floor, Tower B,Building No 10, DLF Cybercity, DLF City Phase II, Gurgaon-122002, Haryana • Insurance is the subject matter of solicitation. • For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale. • IRDA Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

AMHI/PR/H/0022/0084/032082/P

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

OPTIMA CASH

Description- A Hospital Daily Cash Insurance plan that pays lumpsum amount in event of hospitalisation that can be utilized towards hospitalization expenses or additional expenses like attendant's food/ accommodation or travel cost which are not covered under hospitalisation health insurance.

Application No.	Plan Variant	Plan Tenure (1 year/ 2 year)	Premium
OC _____	☐ Gold	☐ 1 year ☐ 2 year	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Daily Cash Amount						
Number of Days (90/180Days)						

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.

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 defense, 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.

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

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☐ I/we declare and further consent to the company. seeking medical information from any hospital Iwho 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.

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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: _____

AMHI/PR/H/0022/0084/032082/P

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

INDIVIDUAL PERSONAL ACCIDENT

Description- A Individual Personal Accident insurance product that provides financial compensation in the unfortunate event of an accident leading to the death or disablement of the insured.

Application No.	Plan Variant	Rider (if Opted)	Premium
IP _____	☐ Standard ☐ Premium	☐ Temporary Total Disablement	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Sum Insured						
Temporary Total Disablement						

Note: Temporary Total Disablement rider [TTD]: 100% of AD Sum Insured; maximum Rs. 5,00,000 in case of standard and 100% of AD Sum Insured maximum Rs. 15,00,000 in case of a premium plan.

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.

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

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Signature of Proposer: _____ Date: _____ Place: _____

Name of the witness: _____

Signature of witness: _____ Date: _____ Place: _____

AMHI/PR/H/0022/0084/032082/P

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

OPTIMA SENIOR

Description- A inpatient health insurance product specially designed for senior citizens providing coverage for medical treatment due to illness or accident.

Application No.	Plan Type	Plan Tenure (1 year/ 2 year)	Premium
OS _____	☐ Individual	☐ 1 year ☐ 2 year	

PLAN DETAILS	Member 1	Member 2
Sum Insured		

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 internal or 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

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Signature of Proposer: _____ Date: _____ Place: _____

Name of the witness: _____

Signature of witness: _____ Date: _____ Place: _____

AMHI/PR/H/0022/0084/032082/P

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

OPTIMA SUPER

Description-Optima Super is India's only Top-up Health plan with an option of converting into a full-fledged nil deductible Health Insurance plan when you retire. Firstly, you pay a nominal premium for the top-up that helps you cover higher medical spends. Secondly, when you retire, it gives you an option to opt for a regular plan with nil deductible.

Application No.	Plan Tenure (1 year/ 2 year)	Premium
SU _____	☐ 1 year ☐ 2 year	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Sum Insured						
Deductible						

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 48 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 internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy; sleep apnoea; venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus)' sterility / infertility treatment of any type; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; 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; dental treatment unless requiring hospitalization; treatment of nasal concha resection, 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, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment; 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; enteral feedings 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; charges related to a Hospital stay not expressively mentioned as being covered, 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 or who is a member of an Insured Person's family; the 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; any treatment or part of treatment that is not of a reasonable cost, not medically necessary; drugs or treatment which are not supported by a prescription; artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment.

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 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 further consent to the company. seeking medical information from any hospital Iwho 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.

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: E-mail : customerservice@apollomunichinsurance.com Toll Free : 1800-102-0333

Apollo Munich Health Insurance Co. Ltd • Reg Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad -500033 AP. • Corp. Off. 10th Floor, Tower B,Building No 10, DLF Cybercity, DLF City Phase II, Gurgaon-122002, Haryana • Insurance is the subject matter of solicitation. • For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale. • IRDA Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

AMHI/PR/H/0022/0084/032082/P

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

OPTIMA VITAL

Description-A benefit policy that pays a lump sum benefit (upto the Sum Insured opted) on the first diagnosis of the critical illnesses covered in the insurance plan on completion of the survival period.

Application No.	Plan Tenure (1 year/ 2 year)	Premium
OV _____	☐ 1 year ☐ 2 year	

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Sum Insured						

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.

90 days waiting period in the first year and is not applicable in subsequent renewals, 4 years waiting period for any pre-existing condition.

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 a professional or semi professional nature.

Medical - Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol. Any treatment arising from pregnancy (including voluntary termination), miscarriage, maternity or birth (including caesarean section). Congenital internal or external diseases, defects or anomalies, genetic disorders. Any critical illness in presence of HIV infection and / or any AIDS . Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured, as per Our underwriting guidelines.

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 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 further consent to the company. seeking medical information from any hospital Iwho 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.

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: _____

AMHI/PR/H/0022/0084/032082/P