Optima Plus
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. 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 or non-fullfillment of pre-policy check-up.

Please fill-up this form in CAPITAL LETTERS and attach a passport sized photograph of yourself and each proposed insured person and write the name of the person above the photograph.

1. PROPOSER DETAILS

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

Nationality : _____ Marital Status : _____ Annual Income : _____

Profession : Salaried ☐ Self Employed ☐ Others ☐ Details _____

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

ID Proof No. :

2. PLAN DETAILS

Sum Insured : Rs. 500,000

Deductible : Rs. 100,000 ☐ Rs. 200,000 ☐ Rs. 300,000 ☐ Rs. 400,000 ☐ Rs. 500,000 ☐

Proposed Policy Period : 1 year ☐ / 2 year ☐ From D D M M Y Y Y Y To D D M M Y Y Y Y

3. PROPOSED INSURED(S) DETAILS

Details of Person Proposed to be Insured

Insured 1 : Name : Mr./Ms./Mrs.							
Height	cms	Relationship		Date of Birth	D D M M Y Y Y Y	Occupation	
Weight	kg	Gender	Male ☐ Female ☐				
Insured 2 : Name : Mr./Ms./Mrs.							
Height	cms	Relationship		Date of Birth	D D M M Y Y Y Y	Occupation	
Weight	kg	Gender	Male ☐ Female ☐				
Insured 3 : Name : Mr./Ms./Mrs.							
Height	cms	Relationship		Date of Birth	D D M M Y Y Y Y	Occupation	
Weight	kg	Gender	Male ☐ Female ☐				
Insured 4 : Name : Mr./Ms./Mrs.							
Height	cms	Relationship		Date of Birth	D D M M Y Y Y Y	Occupation	
Weight	kg	Gender	Male ☐ Female ☐				
Insured 5 : Name : Mr./Ms./Mrs.							
Height	cms	Relationship		Date of Birth	D D M M Y Y Y Y	Occupation	
Weight	kg	Gender	Male ☐ Female ☐				
Insured 6 : Name : Mr./Ms./Mrs.							
Height	cms	Relationship		Date of Birth	D D M M Y Y Y Y	Occupation	
Weight	kg	Gender	Male ☐ Female ☐				

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 details

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

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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

*If the Nominee is minor, Name and Address of Assignee and Relationship with Minor:

Assignee Name	Relationship	Address of the Assignee

5. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or any of the persons proposed, already insured under a plan with Apollo Munich Health Insurance Co. Ltd. or any other insurer or is a proposal pending for Policy issuance? ☐ Yes ☐ No

If yes, please indicate below the Policy/ Application number(s) (Please mention application number in case of pending proposal.)

Since when are you continuously insured: D D M M Y Y Member ID _____ Employee ID _____

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

6. MEDICAL AND LIFE STYLE INFORMATION

IMPORTANT: You must answer these questions truthfully.
Not doing so affects your coverage in case of a Claim

☑ Signature of the Proposer

Medical History: Please answer the below mentioned questions Yes (Y) or No (N) ONLY:

Section A : Have any of the persons 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.	Hypertension, chest pain, Ischemic heart disease or any other cardiac disorder	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), hepatitis, cirrhosis or any other Digestive or Liver/ Gallbladder disorder	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
iv.	Renal failure, calculus or any other Kidney/Urinary tract or Prostate disorder	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
v.	Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous system disorder	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
vi.	Diabetes, Thyroid disorder or any other endocrine disorder	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
vii.	Tumor-benign or malignant, any ulcer/growth/cyst	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 Nose/Ear/Throat/Teeth/ Eye (please mention Diopters)	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.	Anaemia, Leukaemia 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.	DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐

Section B : Have any of the persons proposed to be insured:							
xiv.	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☐
xv.	Been under any regular medication (self/ prescribed)	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
xvi.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
xvii.	Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
xviii.	Suffered from any other disease/illness/accident/injury	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐

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xix.	Is any of the insured persons pregnant? If yes, please mention the expected date of delivery_____	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
xx.	Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐

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

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

Section E : 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**	**Smoke**	**Pan Masala**	**Others**
Insured Person 1 :				
Insured Person 2 :				
Insured Person 3 :				
Insured Person 4 :				
Insured Person 5 :				
Insured Person 6 :				

Section F : 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 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☐

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 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.

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

I have read the below mentioned exclusions carefully. ☑ 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.
30 days waiting period in the first year and is not applicable in subsequent renewals; 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

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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.

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. 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 Ltd.

☐ I further consent and authorize Apollo Munich Health Insurance Company Ltd. and/or any of their authorized representatives to seek medical information from any hospital/consultant/insurer that I or any person proposed to be insured has attended or may attend in future concerning any disease or illness or injury in respect to a particular claim.

☐ 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 : D D M M Y Y

Place :

Vernacular Declaration :

Signature of the Proposer : ☑

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 : ☑

Date : D D M M Y Y

Place :

Signature of the witness : ☑

Name of the witness : ☑

Insurance is the subject matter of solicitation

10. AGENT'S DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No. (Advisor/Corporate Agent/Broker/Relationship Officer) :

Date : D D M M Y Y

Place :

Signature of Agent : ☑

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 : 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

12. FOR OFFICE USE ONLY

Apollo Munich Health Office Code	:		Advisors Code & Name :
Branch Receipt Date	:		Channel Type :
Business Type	:	Urban/ Rural/ Social	