

Please provide name and contact details of Your treating or family doctor : _____

PAYMENT DETAILS

Instrument type Cash/Cheque/Debit/Credit Card/ Others	Instrument No.	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 a separate sheet to this proposal and return it to us.]

GENERAL EXCLUSIONS

Following is an outline of the exclusions under the policy. Specific additional exclusions apply to various benefits under the policy. For more details on the exclusions & waiting periods please refer the policy wordings before purchasing this policy.

We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy: War, war like operations; nuclear weapons/materials radiation of any kind; committing or attempting to commit a criminal or unlawful act; participation or involvement in naval, military or air force operation or any hazardous ; abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol; treatment of nicotine addiction or any other substance abuse; intentional self injury or attempted suicide; obesity/morbid obesity and any weight control program; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus), venereal disease, sexually transmitted disease; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; non allopathic treatment; charges related to a Hospital stay not expressly mentioned as being covered; Personal comfort and convenience items, vitamins and tonics; treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; out-station consultations and referral-fees; treatments by a Medical Practitioner who shares the same residence as an Insured or 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, diabetic test strips, and similar products; any treatment that is not medically necessary; where purpose of travel is to obtain medical treatment; treatment of any pre-existing condition, cancer, orthopedic, degenerative or oncology diseases unless to save life in an unforeseen emergency or to relieve acute pain; cosmetic treatment; congenital internal or external disease.

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 terms. 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 doubt, please seek the advice of your insurance advisor.

DECLARATION & WARRANTY ON BEHALF OF ALL THE 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 authorise Apollo Munich Health Insurance Company Limited. and/or any of its 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.

Signature of the Proposer:

Signature of the Advisor:

Date: Place:

INSURANCE IS THE SUBJECT MATTER OF SOLICITATION

FOR OFFICE USE ONLY

Apollo Munich Health Office code:

Advisor code & Name:

Branch Receipt date:

Channel Type:

Business Type: Urban / Rural / Social