Individual Personal Accident
Proposal Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Application No. : _____

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 if premium is not received by us in full and in time, or is not realised. Please fill-up this form in CAPITAL LETTERS

PROPOSER DETAILS

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

Nationality : _____

Profession : Salaried ☐ Self Employed ☐ Others ☐ Details _____

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

ID Proof No. :

PLAN DETAILS (Please refer to the brochure for details of benefits under plans Standard & Premium & select the appropriate option below)

Standard Plan ☐ Premium Plan ☐

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

PROPOSED INSURED(S) DETAILS: Name of the persons proposed to be insured (including proposer)

S No.	Mr./Ms./Mrs. Name of the person to be insured	Relationship	Gender Male Female	Date of Birth	Accidental Death Sum Insured	Temporary Total Disablement Sum Insured
1						
2						
3						
4						
5						
6						

OCCUPATION & INCOME DETAILS (same order must be maintained as above)

	Occupation & Designation	Organisation	Nature of duties	Annual Income (in Rs.)
Proposed Insured 1				
Proposed Insured 2				
Proposed Insured 3				
Proposed Insured 4				
Proposed Insured 5				
Proposed Insured 6				

NOMINEE DETAILS

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee and his/her receipt of the proceeds would be sufficient discharge to the company. The nominee must be an immediate relative of the Proposer. Nominee for all other persons proposed to be insured shall be the Proposer himself/herself. The following section to be filled for the Proposer

Nominee Name	Relationship	Address of the Nominee

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

Appointee Name	Relationship	Address of Appointee

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EXISTING INSURANCE DETAILS

Is the proposer or any of the persons proposed, already insured under or proposed for a personal accident insurance policy with Apollo Munich Health or any other insurance company? If yes, please indicate below the Policy/Application number(s) (Please mention application number incase of pending proposal):

Policy No. / Application No.	Insurer	From (Date)						To (Date)						Sum Insured	Claim Details (If any)
		D	D	M	M	Y	Y	D	D	M	M	Y	Y		

MEDICAL & LIFE STYLE INFORMATION (if your answer to any of the below is 'yes', kindly attach the details in an extra sheet duly signed)

Please answer the below mentioned questions in Yes(Y)/No (N):

In relation to each of the insured persons	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
i. Have you in the past or are you currently suffering from any physical or mental defects/impairment/ infirmity/deformity or any condition that may effect your mobility/sight/hearing/speech?	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
ii. Have you in the past or are you currently suffering from or have you taken or are you taking treatment for arthritis, gout, paralysis, epilepsy or any other seizure disorder?	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
iii. Does your occupation require you to engage in significant manual labor or hazardous activities or requires handling hazardous material or working at height or with high voltage?	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐

PAYMENT DETAILS

Instrument type Cash/Cheque/Debit/Credit Card/ Others	Instrument No.	Bank Details	Date						Amount (in Rs)
			D	D	M	M	Y	Y	

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 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.

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.

You are obliged to inform Apollo Munich Health Insurance Company Ltd without any delay and in writing of all doctors or other members of the medical profession whom you

or any of the proposed member have consulted and all changes in your or any other proposed members' state of health or occupation between the filing of this application form and the inception of your insurance cover. 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/ We hereby declare, on my behalf and on behalf of all persons proposed to be insured that the above statements, answers and/or particulars given by me 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 consent to the company seeking medical information from any hospital who at anytime has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- ☐ I/ We authorize 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 the Proposer: Signature of the Advisor:

Date: D D M M Y Y Place:

Vernacular Declaration

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than the 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: D D M M Y Y Place: Name of the witness:

Date: D D M M Y Y Place:

Insurance is the subject matter of solicitation

12. FOR OFFICE USE ONLY

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

CHECK LIST (Please check the following documents are attached along with the proposal form)

ID Proof ☐ Proof of residence ☐ Age proof ☐ Income proof ☐

How did you come to know about our company and our products?

Television Advt. ☐ Radio Jingle ☐ Hoarding ☐ Point of sale ☐ Word of mouth ☐

Road show ☐ Exhibition counter ☐ Sponsor program ☐ Brochure ☐ News paper/Magazine ☐

Others, please specify _____

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NEFT details

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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.

Proposer/Policy holder's Signature ☑ Date : D D M M Y Y

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**

AMHI/PR/H/0003/0003/102010/P

IPA/PF/V0.02/062013

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Acknowledgement

ApolloMunich HEALTH INSURANCE

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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

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