Optima RESTORE
Proposal Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Application No. : _____

The information provided by me in this document is True to the best of my knowledge.

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 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 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-fulfillments of Pre Policy Checkup.

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

1. PROPOSER DETAILS

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

☐ **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**

Nationality : _____ Marital Status : _____ Annual Income : _____

Profession : Salaried ☐ Self Employed ☐ Others ☐ Details _____

ID Proof Type : PAN ☐ Passport ☐ Driving License ☐ Voter's Card ☐ Other ☐ Details _____

ID Proof No. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. PLAN DETAILS

Coverage : Individual ☐ Floater ☐	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 ☐	Basic sum insured**:	
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 ☐	Basic sum insured**:	
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 ☐	Basic sum insured**:	
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 ☐	Basic sum insured**:	
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 ☐	Basic sum insured**:	
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 ☐	Basic sum insured**:	

* Gender Code - M (Male), F(Female) ** Family Floater policy will have same basic Sum Insured for all members (See brochure for floater policy details)

PHOTOGRAPHS

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(s) 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. Nominee for any of the persons proposed to be insured shall be the Proposer.

Nominee Name	Relationship	Address of the Nominee

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

Assignee Name	Relationship	Address of the Assignee

5. 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.	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		

* Please note that continuity of benefits shall NOT be considered if the Above question of want of continuity is not replied affirmative, details are not provided and Portability form and relevant supporting documents are not submitted.

6. MEDICAL AND LIFE STYLE INFORMATION

Important: You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim.

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

Section A : Have any of the person 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 other than routine health check-up or pre-employment check-up?	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 other than common cold or fever?	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐	Y☐/N☐
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 above)	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, 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☐

7. PAYMENT DETAILS

Mode of Payment:: Cash / Cheque / Debit Card / Credit Card / Electronic Clearing System*/ Others _____

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

*If ECS is selected, please submit the standing instruction form available at our branches.

Please make a A/c Payee Cheque/DD/Pay Order in favour of **'Apollo Munich Health Insurance Company Limited'** only.

Section 41 of Insurance Act1938 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

2. Any person making default in complying with the provision 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 (UNDER THE POLICY) FOR MORE DETAILS PLEASE REFER TO THE POLICY WORDINGS

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 Periods - 30 days waiting period in the first year and is not applicable in subsequent renewals. 2 years waiting period for the specified illnesses/ surgeries. 3 years waiting period for Pre-existing conditions. 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. Medical - 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 and any weight control program. 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, Cancer or Burns. Treatment for correction of eye due to refractive error. Circumcisions (unless necessitated by illness or injury and forming part of treatment); Aesthetic or change-of-life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance driven by cultural habits, fashion or the like or any procedures which improve physical appearance. Non allopathic treatment. Conditions for which Hospitalization is not required. Experimental, investigational or unproven treatment devices and pharmacological regimens. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done. Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite

treatment); any physical, psychiatric or psychological examinations or testing. Enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) 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. Save 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. Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively). Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), sleep-apnoea. Congenital internal or external diseases, defects or anomalies, genetic disorders. Stem cell therapy 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. 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 in relation to in-patient only. 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. Expenses for organ donor screening, or save as and to the extent provided for in Organ Donor Benefit-Organ Donor, the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery). 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 treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls (wherever specifically charged for), foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies. vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Treatment 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 is a member of the insured's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by a prescription. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing. Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured. The costs of any procedure or treatment by any person or institution that We have told You (in writing) is not to be used at the time of renewal or at any specific time during the policy period.

9. 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, 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 :

Date : D D M M Y Y 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).

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 :

Name of the witness :

Date : D D M M Y Y

Place :

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 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 : D D M M Y Y Place :

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	

Optima RESTORE

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.

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**

OR/PF/V0.03/072013

AMHI/PR/H/0003/0102/032013/P

Optima RESTORE

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

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