Change Request form

ApolloMunich HEALTH INSURANCE

Let's Uncomplicate

Policy Number:	
Name of Proposer:	

Please tick the appropriate box and fill the details in the corresponding section:

1. Change in Address ☐ 2. Change in Tenure ☐ 3. Change in Sum Insured ☐ 4. Member Addition/ Deletion ☐ 5. Change in Product ☐ 6. Others ☐

I want to opt for a) Protector Rider^ ☐ b) Individual Personal Accident Rider* ☐ c) Hospital Daily Cash Rider^ with Sum Insured: ₹ 1000 per day ☐ ₹ 2000 per day ☐ ₹ 3000 per day ☐

* Sum Insured under Individual Personal Accident rider will be 5 (five) times the Sum Insured of Optima Restore (Base Plan) upto a maximum of Rs. 1 Crore and this rider will be offered only to the Proposer. ^Protector Rider and Hospital Daily Cash Riders will be offered on individual sum insured basis if the base plan is on individual sum insured basis or floater sum insured basis if the base plan is on floater sum insured basis. Protector Rider and Hospital Daily Cash Riders will be available on all or none basis.

I want to add a Plus to my health Insurance. Yes ☐ No ☐

1. New Address (Address proof to be enclosed)

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

2A. I want to opt for 2-year plan ☐ 2B. I want to opt for 1-year plan ☐

3. Change in Sum Insured

Name of Insured:	

Existing Sum Insured: _____ Desired Sum Insured: _____

4. Member Deletion/ Addition

Name of Insured:			
Date of Birth	D D M M Y Y Y Y	Gender	Male ☐ Female ☐
Relationship with proposer:			

Reason for deletion: _____

For addition of any individual, fresh proposal form should be filled.

5. Change in Product

Name of Insured:			
Existing Product:		Desired Product:	
Desired Sum Insured/ Deductible (in case of Optima Plus product):		Desired Plan Variant	
Individual/ Floater		Height/ Weight*	

** To be filled only incase Insured shifted from Optima Cash Product*

Note: Please enclose an additional sheet for change in sum insured/ change in product for more than one member

Health Status Declaration : Post commencement of your insurance policy with us, did you suffer from or are currently suffering from or have developed any disease/ illness/ injury or accident/ medical condition other than common cold or fever? ☐ Yes ☐ No

If answer is yes, please provide all the relevant documents/ information including but not limited to Doctors prescription, Medical Test Reports etc.

Please note: Any Non Disclosure or Incomplete/ incorrect/ partially correct information may lead to repudiation of claim or cancellation of policy as per policy terms and conditions.

If Sum Insured Change is desired for more than one member, please use additional sheet to give information.

(Applicable for Easy Health, Optima Restore, Optima Plus, Maxima, Optima Senior, Optima Cash, Individual Personal Accident Product.)

6. Others, please furnish details: _____

we accept and agree that:

1. I/ We may have to undergo fresh pre policy health checkup as a result of opting for (i) increase in sum insured and/or (ii) addition of critical advantage rider/ critical illness rider and/ or (iii) Addition of insured member/ change in product.
2. I/ We shall comply with any other additional requirements including payment of additional premium towards risk loading, if any, within 7 days from the date of such written communication received from AMHI
3. I/ We authorize AMHI to renew the Existing Policy under its existing terms and conditions if I/ We fail to comply with either of the above stipulations"
4. I hereby declare and warrant that on my behalf and on behalf of all the insured that all the information provided above are true and complete in all respect and no other information which is relevant in the context has been supressed.

Signature of Proposer/ Policy Holder: _____ Date: _____

Certification in case the Proposer has signed in vernacular : (The below must be witnessed by someone other than the agent/ employee of the company)

The contents of this form and its particulars have been explained by me in vernacular to the Executant.

Signature of the Proposer: _____ Signature of the Witness: _____

Name of Witness:	
Address:	
Contact Number:	

Apollo Munich Health Insurance Company Ltd. reserves the right to accept/ reject any changes requested. Certain changes may require additional premium, letters to this effect would be sent

Enclosures: (if any) 1. _____ 2. _____ 3. _____

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