PROPOSAL FORM

HOSPITAL DAILY CASH INSURANCE POLICY

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Guidelines for completion of the form: 1) Please answer all the questions fully and accurately. Where any question does not apply, please mention clearly that the same is not applicable. 2) Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. If you think any fact is material, please disclose it. 3) The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or anyone acting on Proposer's behalf. Kindly contact SBI General Offices or Agents for any doubts or clarifications on the proposal form.

Important Information: Health Check Up/ Medical Examination will be required for acceptance of the proposal based on the Medical history, Sum Insured & age of the Proposer as per our guidelines. For all persons aged 60 and above, medical examination is compulsory, irrespective of the Sum Insured opted and pre-acceptance medical tests at the cost of the Proposer. However, if the Proposal is accepted the Insurer will reimburse 50% of the cost incurred towards the medical tests so undertaken at the advice of the Insurer.

FOR OFFICE USE

Quote No.: Inward No.:

Receipt No.: Receipt Date: D D M M Y Y Y Y

INTERMEDIARY'S DETAILS (* Mandatory Fields if Sales Channel Type selected is Banca)

Segment Type: ☐ Corporate ☐ Retail ☐ SME

Business Sector: ☐ Urban ☐ Rural ☐ Social

Business Type: ☐ New ☐ Roll-Over ☐ Renewal

Sales Channel Type: ☐ Banca ☐ Agency ☐ Direct

Sales Channel Code: Specified Person's Code*:

Specified Person's Name*: GSTIN/ISDN: IF APPLICABLE

PROPOSER DETAILS (* Mandatory Fields)

1. Do you have existing relationship with SBI General Insurance*? ☐ Yes ☐ No If Yes, then please mention the Customer ID:

2. Name*: S U R N A M E M I D D L E N A M E F I R S T N A M E

3. Proposer's Permanent Residential Address*:

City: Pin code: State:

4. Nationality*: 5. Preferred Contact Mode (Please Tick ✓)*: ☐ Email ☐ Paper Mail ☐ Phone

6. Contact Details*: Mobile No.: Alternate Mobile Number:

7. Email Address*: 8. Preferred Payment Mode: ☐ EFT ☐ Cheque

9. Gender*: ☐ Male ☐ Female ☐ Other 10. Marital Status: ☐ Married ☐ Single 11. Date of Birth*: D D M M Y Y Y Y

12. Aadhaar Card No.: 13. PAN*: /Form 60/61* (If PAN not available): ☐

14. Passport/Driving License/Voter ID:

15. What industry do you work in?*

16. Occupation*: ☐ Salaried ☐ Self Employed/ Professional ☐ Business ☐ Student ☐ Retired ☐ Agriculture & allied ☐ Others (specify_____)

17. Period of Insurance: From D D M M Y Y Y Y To D D M M Y Y Y Y

18. Are you one among the Insured Persons Covered below? Yes ☐ No ☐

19. Are you or any of the proposed applicant_____, please tick whichever is applicable: Yes ☐ No ☐

HNI ☐ Jeweller ☐ NGO ☐ Film Actor/ Producer ☐ PEP ☐

If yes, please provide details for all person(s) in a separate sheet.

Politically Exposed Persons (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials.

Version: 1.0 Jan 2024

ACKNOWLDEGEMENT SLIP (Tear Off):

This is to certify that the amount of ₹ _____ will be debited from the Bank Account No. _____ of

Mr./Ms./Mrs._____ towards premium for SBI General's Hospital Daily Cash Insurance Policy.

Signed at:_____ Journal No.:_____ Authorised Signatory for SBI General

Signature: _____ Journal Date: D D M M Y Y Y Y _____

Version: 1.0 Jan 2024

DETAILS OF PERSONS TO BE INSURED

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of the Insured*						
Sum Insured*						
Date of Birth*						
Age*						
Gender*						
Height*						
Weight*						
Occupation*						
Nationality* (Indian/ Non-Indian/ Non-resident Indian/ Other)						
Marital Status*						
Relationship with Proposer*						
Nominee*						
Appointee*						
Pre-existing disease/s*						
ABHA (Ayushman Bharat Health Account) number (if available) :						
Benefit Amount/Sum Insured :	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day
Sum Insured Option:	☐ Individuat ☐ Individual with family					
Sum Insured Plan:	☐ 30 Days ☐ 60 Days					

I/We hereby provide consent to share my/our medical records with the insurer or TPA ☐

If ABHA number is not available, it can be created at www.healthid.ndhm.gov.in

Note: Here Family Includes Self, Spouse, Dependent Children, Dependent Parents & Dependent Parents in law (Maximum up to 6 members can be covered under one policy)

NOMINEE DETAILS

Name	Contact Details	Date of Birth	Age	Relationship with primary insured
		D D M M Y Y Y Y		

Where Nominee is a minor, give the details of Appointee

Name of the Appointee	Relationship	Appointee contact details

PREVIOUS/EXISTING INSURANCE

Are you applying for portability / Migration: Yes ☐ No ☐

(If "Yes", please fill the separate portability from also)

Does any person to be insured presently hold any Health Insurance / Critical Illness Insurance Policies with SBIG or any other insurer?

Yes ☐ No ☐ If Yes, then provide below details

ACKNOWLDEGEMENT SLIP (Tear Off):

Note: (1) You shall receive the Policy copy on acceptance of your Proposal Form to the Head Office of SBI General Insurance Company. (2) Irrespective of the number of accounts the Insured has with SBI, he/she is allowed to take only one Policy. Multiple Policies for the same Insured are disallowed. (3) Even if multiple Policies are taken through one or more than one account with SBI for any reason, our liability will be restricted to only one Policy with the highest Sum Insured. All other Policies shall be deemed as null and void. Premium paid for all such Policies by Insured will be refunded after deduction of administrative expenses of ₹150. (4) In case of a Joint Account, two separate Policies may be issued in case both the account holders opt for respective Individual Policies. (5) Period of Insurance shall be 1 year from the date of transaction. (6) This acknowledgement slip does not in any way communicate the acceptance or commencement of risk under the application submitted by you. This is only an acknowledgement slip and is not the premium receipt. This acknowledgement slip should not be used for Income Tax purpose. The premium receipt shall be issued once the Company accepts the risk on your health and the amount deposited is applied to your Policy as premium. (7) Premium will be refunded in case your proposal is rejected by us. (8) For any assistance/ clarification required, kindly get in touch with SBI General Insurance Company Ltd. on 1800 22 1111, 1800 102 1111 (Toll Free).

Previous / Existing Insurance Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Policy Number						
Insurer's Name						
Period of Insurance						
Sum Insured						
Premium Paid (Rs)						
Claim Details (if any) Incurred Claim (Outstanding + Received): Claim Ratio (%):						

PERSONAL HEALTH DETAILS (To be filled in respect of all the members proposed to be covered under the policy)

Sr. No.	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Are you in good health and free from physical and mental diseases or infirmity or medical complaints or deformity?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2	Lifestyle details of the Insured:						
2a	Is your occupation associated with any specific hazard? (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals etc.)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2b	Do you consume tobacco in any form? If Yes, whether it is: Cigarette/Beedi/Cigar/Gutka/Pan Masala/Others.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	Quantity per day:						
	Consuming for past:	_____years	_____years	_____years	_____years	_____years	_____years
	If you have stopped smoking or using tobacco products then please mention from when?						
2b	Do you consume alcohol? If Yes, type of alcohol: Beer/ Hard liquor/Wine/Others:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	Amount consumed per week:						
	Consuming for past:	_____years	_____years	_____years	_____years	_____years	_____years
	If you have stopped drinking then please mention from when?						
3	Have you ever suffered or taken treatment or have been recommended to take medication for the following by a medical practitioner?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3a	High Blood Pressure/Heart Attack/Cardiovascular disease, Diabetes, Tuberculosis, Asthma, or other Respiratory Disease, Kidney disorder, Bladder disorder, Urine abnormality, Renal stones or Genital organ disorder, Cancer or any form of Tumour or Lump, Cyst growth, Liver and Gall bladder disorder, Stomach or Duodenal disorder, Fistula, Piles, Hernia, Eye, Ear, Nose, Throat or Endocrine diseases, Diseases of bones, joints or spine, Stroke, Eplilepsy or any other disorder of Brain, Spinal cord or Nerves.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3b	Any other illness/injury requiring investigation or treatment	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If answer to 3a or 3b is 'Yes', provide details of the ailment and nature of treatment in the Annexure.						
4	Have you ever been tested positive for HIV/AIDS, Hepatitis B or C or sexually transmitted diseases?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want Hospital Daily Cash Insurance Policy and related information in: ☐ Physical Format ☐ e-Format (electronic); as & when applicable.

Choose your Insurance Repository (For those selecting e-Format)

☐ NSDL Data Management Ltd. ☐ CDSL Insurance Repository Ltd. ☐ Karvy Insurance Repository Ltd. ☐ CAMS Repository Services Ltd.

☐ I have an e-Insurance Account & the No. is ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

My CKYC No. (Central Know Your Customer Registry Number) is ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (If available).

I, _____, hereby grant explicit consent to SBI General Insurance Company for the retrieval and downloading of my CKYC record from the Central KYC Records Registry. I understand that this information is essential for the purpose of ensuring accurate and updated records for insurance services. I acknowledge that SBI General Insurance Company will handle my CKYC information in compliance with all applicable data protection laws and regulations. This consent is valid until revoked in writing by me. I have read and understood the terms and conditions regarding the usage of my CKYC information and voluntarily provide my consent.

Customer Name: _____ Date: D D M M Y Y Y Y

Kindly visit our website www.sbigeneral.in to view the list of KYC OVD (Officially Valid Documents).

PAYMENT DETAILS

Journal Entry No.: Journal Entry Date: D D M M Y Y Y Y

Bank A/C No.:

Premium Amount in figures (including Goods and Services Tax as applicable)_____ Amount in Words:_____

Bank Branch:_____ Branch Office Code:_____

Signed at:_____ Signature:_____ Authorised Signatory for SBI:_____

Please draw your Cheque (A/c payee only) in the name of **"SBI General Insurance Company Limited"** (*Mandatory fields)

Instrument Type: Cheque/ Debit Card/ Credit Card

Cheque No./DD No.: Amount: Date: D D M M Y Y Y Y

Bank Name: Branch:

Bank Account No.*: IFSC Code*:

SBIGI does not accept Cash for Premium Payments against the Policy.

AML GUIDELINES (Premium Payment shall be made by the Policyholder of the Policy)

I/We hereby confirm that all premiums have been/ will be paid from bona fide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I understand that the Company has the right to call for documents to establish source of funds. The Insurance Company has the right to cancel the Insurance Contract in case I am/ have been found guilty by any competent court of law under any statues, directly or indirectly governing the Prevention of Money Laundering in India.

Nationality: Indian Non-Indian Non-resident Indian(NRI) Others

If Non-Indian please specify the nationality and country address_____

If NRI please give details for resident country and address_____

Type of Organisation: (Only applicable if policy issued on Group Basis)

Corporation Government Non-Governmental Organisation Society Trust

Partnership International Organisation Cooperative Section 25 Companies

I hereby declare that the current address is different from the avalilable in the Central identities Data Repository. Yes No. Customer can submit CKYC form for updation.

Recent photograph of proposer:
(Photograph is required. if customer does not have CKYC ID)

Signature of Proposer :

SECTION 41 OF INSURANCE ACT, 1938

1. No person shall or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an Insurance in respect of any kind of risk relating to lives or property in India, any rebate of whole or part of the commission payable or any rebate of the premium shown in 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 published prospectuses or tables of the Insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend up to ₹ 10 Lacs.

DECLARATION BY PROPOSER

1. I/We hereby declare on my/our behalf and on behalf of all the persons proposed to be Insured, that the above statements, answers and/ or particulars given by me/us are true and complete in all respects to the best of my/our knowledge and that I/We am/are authorised to propose on behalf of these other persons.
2. I/We understand that the information provided by me/us will form the basis of the 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.
3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the person to be Insured / Proposer after the proposal has been submitted but before communication of the risk acceptance by the Company.
4. I/ We declare that I/ We consent to the Company seeking medical information from any doctor or from a hospital who at anytime has attended on the person to be insured / proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be Insured/ Proposer and seeking information from any Insurance Company to which an application for Insurance on the person to be insured/proposer has been made for the purpose of underwriting the proposal and/ or claim settlement.

5. I/We authorise the Company to share information pertaining to my proposal including the medical records for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/ or Regulatory Authority.

6. I/We aware of premium loading, (if any declared above) for habit's as declared/ mentioned by me /us above.

7. I/ We hereby declare that the premium paid under this transaction is being paid by me/us through a bank account in my/our name or a Credit/Debit Card or through a Prepaid Payment Instrument (Wallet), held by me/us in my/our name as a account holder and is not a third party payment made by any other person on my/our behalf.

Date: D D M M Y Y Y Y Place:

Signature of Proposer:

DECLARATION (If signed in vernacular language / If you have affixed thumb impression above)

Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language.

(Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/We have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us.

I, (Full name of the witness) _____ (Relationship with the Proposer) _____ adult and inhabitant of (City) _____and residing at _____ do hereby certify that I/We have read out and explained the contents of the Proposal Form and all other documents incidental to availing the Insurance Policy from SBI General Insurance Company Ltd., to the Proposer/Primary Insured and he/she/they have understood the same. I/We declare that whatever I/We have stated herein above is true and correct to the best of my knowledge and belief.

Date: D D M M Y Y Y Y

Place:

Signature of the Witness

Signature/Thumb impression of the Proposer

PROPOSAL FORM

HOSPITAL DAILY CASH INSURANCE POLICY

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Annexure to Hospital Daily Cash Insurance Policy

Sr. No.	Particulars	Details
1.	Name of the Insured:	
2.	Name & Address of the treating Doctor:	
3.	Nature of the Ailment (Exact Diagnosis):	
4	Date of the First Diagnosis:	
5.	Nature of Symptoms (Onset, Duration and Intensity):	
6.	List of Prescribed Medication:	
7	Further planned consultation (if any):	
8.	Details of Investigations performed along with the Dates and Results:	

AML Declaration as per AML Master Guideline 2022:

1. Determination of Beneficial Ownership:

I/We hereby confirm that the below mentioned person/s have controlling ownership interest/ exercises control through other means and shall be considered for the purpose of determining Ultimate Beneficial Owner:

Sr. No	Name of Ultimate Beneficial Owner	Percentage (%)*	Remarks, if any

***Notes:**

a) Where the client is a company, the beneficial owner(s) is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has a controlling ownership interest or who exercises control through other means.

1. **"Controlling ownership interest"** means ownership of or entitlement to more than **ten percent of shares or capital or profits of the company;**
2. **"Control"** shall include the right to appoint majority of the directors or to control the management or policy decisions including by virtue of their shareholding or management rights or shareholders agreements or voting agreements;

b) Where the client is a partnership firm, the beneficial owner(s) is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of/entitlement to more than **Ten percent of capital or profits of the partnership.**

c) Where the client is an unincorporated association or body of individuals, the beneficial owner(s) is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of or entitlement to more than **fifteen percent of the property or capital or profits of such association or body of individuals.**

d) Where no natural person is identified under (a) or (b) or (c) above, the beneficial owner(s) is the relevant natural person who holds the position of senior managing official.

e) Where the client is a trust, the identification of beneficial owner(s) shall include identification of the author of the trust, the trustee, the beneficiaries with **ten percent or more interest in the trust** and any other natural person exercising ultimate effective control over the trust through a chain of control or ownership.

Date:

Signature of Policyholder:

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