PROPOSAL FORM





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 45 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											
FOR OFFICE USE								_			
Quote No.:								Inward No.:			
Receipt No.:								Receipt Date:	D D M M Y	YYY	
INTERMEDIARY'S DI	ETAILS (*	Manda	atory Fiel	lds if Sal	les Cl	hanne	el Type	selected is Banca)			
Segment Type:	Corp	orate		Retail			SME	Business Sec	ctor:	Urban Rur	al Social
Business Type:	New			Roll-Ove	er [Renew	al Sales Chann	el Type:	Banca Age	ency Direct
Sales Channel Code:								Specified Pe	rson's Code*:		
Specified Person's Name*:		-		! !							
GSTIN/ISDN:	IF APPLICABLE										
PART I - PROPOSER	(* Mandat	ory Fie	lds)								
1.* Do you have existing r	elationship w	ith SBI	General In	nsurance	?	Yes	No	If Yes, then please ment	tion the Customer ID:		
2.* Title:	Mr.	Miss	Mrs	s. 3.* Na	ame:						
4.* Gender:	Male		emale	Othe	er				5.* Date	of Birth: D D M	M Y Y Y Y
6.* Unique Identification (minimum one is required): PAN Card Ration Card Passport Biometric Card Gov ID Voter's ID Driving Licence											
7.* Unique Identification No.:								8. Aadha	ar Card No.:		
9.* Occupation:	Salari	ed	Self Er Profes	mployed/ ssional		Busi	ness	Student R	Retired Agricul	ture & Others (sp	pecify
10. Email Address:								F	PAN:		/ Form 60:
11. Tel. Details:	Landline No	o.:							Mobile No.*:		
12.* Preferred Contact Mode (Please Tick ✓):	Email		Paper	- Mail	F	Phone	•		13. Preferred	d Payment Mode:	EFT Cheque
14. Period of Insurance:	From	D M	М Ү	YY	Y	Тс	D	D M M Y Y	Y	15. Marital Status:	Married Single
16.*Proposer's Permanen Residential Address:	t										
								City:		Pincode:	
17. Nominee's Name:											
18. Nominee's Date of Birth:	D D M M Y Y Y Y 19. Nominee's Relationship with the Primary Insured:										
20. Appointee's Name:											
22. Are you one among the Insured Persons Covered below? Yes No											
23. Details of Persons/Me	mbers propo									Ι .	Τ .
Details		Pr	imary Ins	ured		Insu	red 1	Insured 2	Insured 3	Insured 4	Insured 5
Name:											
Gender: M/F/Other											

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Deta i																	
Date	etails		Prim	Primary Insured			Insured 1		Insured 2		Insured 3		Insure	14	Insur	ed 5	
	of Birth (DD/MM/	YYYY):															
Relat	onship with the P	roposer:															
Relationship with the Primary Insured:																	
Height (in Metres):																	
Weig	nt (in Kilograms):																
Occu	pation:																
Gross	Monthly Income	:															
Bene	fit Amount/Sum I	nsured:															
Marit	al Status:																
Educa	ational Qualificati	on:															
If any o	f the individual pr	oposed f	or cove	r are not	Covered earlie	r but ar	re beind	g propose	ed now	ı?		Yes	N)			
	S OF COVER SOU y Family we mear		ur legal	Spouse,	Legal & Depen	dent Cl	hildren										
Sun	n Insured Option			Individu	Individual				Individual with Family			Family Floater					
Plar	1			Plan A			P	Plan B				Plan C					
ADD-C	N COVERS:			<u>, </u>													
(1) Rem	oval of Room & IC	CU rent s	ub limit	s? Yes	No	(2) R	emova	l of sub lii	mits or	n operation and co	nsultan	cy cha	rges?	Yes No			
24. Cor	porate			Yes	No			25. GST	N/ISD	N:			IF A	PLICABLE			
PAR	TII - OTHER /	CURRE	NT HE	ALTH IN	ISURANCE II	NFOR	MATIC	ON									
IMPOR	TANT NOTE: Plea	se provi	de deta	ils of any	Individual Heal	th Insu	rance c	over tha	t you h	old with SBI Gene	ral Insur	ance	Company	Ltd. or any ot	her Insurar	ice Compar	ny. Please
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informa	ation.																
1. Do <u>y</u>	you hold or have	any othe	r Healt	h Insurar	ce Policies oth	her tha	n the c	one being	prop	osed now, either	with us	or wit	h other Ir	surers coveri	ing the Indi	viduals pro	posed for
	you hold or have rance now? Yes			:h Insurar	ice Policies otl	ner tha	n the o	one being	g propo	osed now, either	with us (or wit	h other Ir	surers coveri	ing the Indi	viduals pro	posed for
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If you have stopped drinking then please mention from when?

Consuming for past:

No.	Details	Insured	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	
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	
ELE	CTRONIC INSURANCE ACCOUNT DETAILS SECTION							
I want Health Insurance Policy-Retail 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.								
My CKY	C No. (Central Know Your Customer Registry Number) is		(If avail	able).				
Please of Cheque Bank Na Bank Ac VER Applica	MENT DETAILS (Claim/Refund amount will be deposited in this Bank Account only unless chardraw your Cheque (A/c payee only) in the name of "SBI General Insurance Company Limited" No./DD No.: Amount: Amount: Count No.*: NACULAR DECLARATION ble where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or when the below must be witnessed by someone other than the Advisor/Employee of the Company).	Date Branch IFSC Code ³	9: D D	M M	Y Y Y	Y	ory fields)	
further I, (Full r (City) _ docume	ertify that the product applied for by me/us and the contents of the Proposal Form have been clearly of certify that the replies in the Proposal Form have been recorded as per the information provided by me/us name of the witness)	ooser) t and explainer/Primary In	ned the co	ntents of t	adı	ult and inh	abitant of d all other	
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Date:	D D M M Y Y Y Y Place:	Sig	nature/Thu	mb impressi	on of the Pro	poser/Prim	ary Insured	
AML	GUIDELINES							
listed in right to Money Nationa If Non-I	Prevention of Money Laundering Act 2002. I understand that the Company has the right to call for docume a cancel the Insurance Contract in case I am/ have been found guilty by any competent court of law under Laundering in India. Sality: Indian/Non- Indian Indian. Forganisation: Corporation/Government/Non-Governmental Organisation/Society/Trust/Partnership/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society/Indian/Society	nts to estab er any statuo	lish source es, directly	of funds. T or indirect	he Insuran Ily governir	ce Compar	y has the vention of	

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AGENTS DECLARATION	
I,	im/her in this Proposal Form to questions contained herein or any details sought herein r, if this Proposal is accepted by the Company for issuance of the Policy. I have further in this Proposal Form/including addendum(s), affidavits, statements, submissions y be payable and further more if there has been a non-disclosure of any material fact, the
Licence No.	Signature of Agent:
1.I/We hereby declare on my/our behalf and on behalf of all the persons proposed to be in and complete in all respects to the best of my/our knowledge and that I/We am/are a information provided by me/us will form the basis of the Insurance Policy, is subject to the come into force only after full receipt of the premium chargeable. 3. I/We further declare of the person to be insured / Proposer after the proposal has been submitted but before consent to the Company seeking medical information from any doctor or from a hospital or present employer concerning anything which affects the physical or mental health Company to which an application for Insurance on the person to be insured/proposer hall/We authorise the Company to share information pertaining to my proposal includical claims settlement and with any Governmental and/or Regulatory Authority. 6. I/We away / us above.	authorised to propose on behalf of these other persons. 2. I/We understand that the e Board approved underwriting policy of the Insurance Company and that the Policy will that I/we will notify in writing any change occurring in the occupation or general health re communication of the risk acceptance by the Company. 4. I/ We declare that I/ We I who at anytime has attended on the person to be insured / proposer or from any pass of the person to be Insured/ Proposer and seeking information from any Insurance as been made for the purpose of underwriting the proposal and/ or claim settlement. 5 ling the medical records for the sole purpose of underwriting the proposal and/o
Date: D M M Y Y Y Place:	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.

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