

GROUP HEALTH INSURANCE POLICY

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 would be voidable at the option of SBI General Insurance, 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 the Proposer's behalf. (4) 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. (5) 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 the Insured will be refunded after deduction of administrative expenses of ₹150. (6) In case of a Joint account, two separate Policies may be issued in case both the account holders opt for respective Individual Policies. However, only one Policy will be allowed if Family Floater option is opted which can be extended to the family of any one of the joint account holders as per family definition. (7) The premium at the time of the renewal of the Policy would be the applicable premium at the date of renewal and as approved by IRDAI. However, renewal will be subject to the Account of the Insured with SBI being still live and operational. (8) Kindly contact SBI General Offices or Agents for any doubts or clarifications on the proposal form. (9) Period of Insurance shall be 1 year from the date of transaction. (10) Dependent children will be covered up to 18 years of age. (11) Pre-existing diseases would be covered after 4 policy years provided the policy has been renewed without a break.

PRIMARY INSURED'S DETAILS (*Mandatory Fields)

1. *Bank Account No.:

2. *Primary Insured's 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. *Communication Address:

 Pincode:

4. Tel. Details: Landline No.: 5. Mobile No.:

6. Email ID: 7. Total No. of persons to be covered:

8. Preferred Contact Mode: Email Paper Mail Phone (Please Tick) 9. Aadhaar Card No.:

10. GSTIN/ISDN: IF APPLICABLE 11. Corporat: Yes No

12. PAN No*: / FORM 60/61:

| Details | Primary Insured | Spouse | Child 1 | Child 2 |
|---|-----------------|--------|---------|---------|
| Name*: | | | | |
| Existing SBI General Insurance Customer? If Yes, Member ID: | | | | |
| Gender: M/F/Other* | | | | |
| Age*: | | | | |
| Date of Birth (DD/MM/YYYY)*: | | | | |
| Height (in Cm): | | | | |
| Weight (in Kg): | | | | |
| Occupation: | | | | |
| Annual Income: | | | | |

Version: 1.0 May 2020

POLICY RENEWAL ADVICE (Tear Off):

I authorise the Bank for automatic debit of renewal premium of this cover from my account as long as the terms and conditions and the premium payable remain unchanged. I understand that this authorisation can be revoked by me at my will by submitting a written notice to the Bank.

Date: _____

Signature/ Thumb Impression of the Proposer/ Primary Insured

ACKNOWLEDGEMENT 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 Group Health Insurance Policy.

Signed at: _____

Journal No.: _____

Authorised Signatory for SBI General

Signature: _____

Journal Date: D D M M Y Y Y Y

Disclaimer: SBI General Insurance Company Limited | Corporate & Registered Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai 400 099. | For more details on the risk factor, terms and conditions, please refer to the Sales Brochure and Policy Wordings carefully before conducting a sale. | For SBI General Insurance Company Limited IRDAI Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546 | SBI Logo displayed belongs to State Bank of India and used by SBI General Insurance Company Limited under licence. | Group Health Insurance Policy UIN: SBIHLGP21330V022021 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

Version: 2.0 Jan 2023

DETAILS OF COVERAGE SOUGHT

* Mandatory

Note: By Family we mean You, Your Legal Spouse, Legal & Dependent Children. (Primary Insured & Spouse aged 18 to 65 years; Dependent Children aged 3 months to 18 years).

| Product Type | Plan Opted | Sum Insured Option in ₹ | | | | |
|---|---|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Self Only (1A) | <input type="checkbox"/> 100000 | <input type="checkbox"/> 200000 | <input type="checkbox"/> 300000 | <input type="checkbox"/> 400000 | <input type="checkbox"/> 500000 |
| <input type="checkbox"/> Family Floater | <input type="checkbox"/> 2A <input type="checkbox"/> 2A+1C <input type="checkbox"/> 2A+2C <input type="checkbox"/> 1A+1C <input type="checkbox"/> 1A+2C | <input type="checkbox"/> 100000 | <input type="checkbox"/> 200000 | <input type="checkbox"/> 300000 | <input type="checkbox"/> 400000 | <input type="checkbox"/> 500000 |

OTHER / CURRENT HEALTH INSURANCE INFORMATION

IMPORTANT NOTE: Please provide details of any Health Insurance cover that you hold with SBI General Insurance Company Ltd. or any other Insurance Company. Please note that the information provided hereunder has a bearing on the admissibility of the claim, if any under the Policy proposed and hence request you to provide complete and exact information.

| Sr. No. | Details | Primary Insured | Spouse | Child 1 | Child 2 |
|---------|---|--|--|--|--|
| 1. | Do you hold any other Health Insurance Cover? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. | If Yes, with whom? (Insurance Company's Name): | | | | |
| 3. | Type of Policy / Product: | | | | |
| 4. | Insured since? | | | | |
| 5. | Period of Insurance (From: DD.MM.YYYY To: DD.MM.YYYY): | | | | |
| 6. | Sum Insured: | | | | |
| 7. | Any Special Condition or Exclusion? If Yes, please provide details for the same: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. | Have you made any Claim in the Policy? If Yes, please provide reason for claim and claimed amount: | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PERSONAL HEALTH DETAILS (To be filled by all the members under the Policy or proposed to be covered under the Policy).

| Sr.No. | Details | Primary Insured | Spouse | Child 1 | Child 2 |
|--------|---|---|---|---|---|
| 1. | Do you smoke cigarettes or consume tobacco (chewing paste)/alcohol in any form? | <input type="checkbox"/> Cigarette <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> None | <input type="checkbox"/> Cigarette <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> None | <input type="checkbox"/> Cigarette <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> None | <input type="checkbox"/> Cigarette <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> None |
| 2. | Has any of the persons to be Insured suffer from /or have been investigated for any of the following? | <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Stroke <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cancer <input type="checkbox"/> AIDS or HIV Positive | <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Stroke <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cancer <input type="checkbox"/> AIDS or HIV Positive | <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Stroke <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cancer <input type="checkbox"/> AIDS or HIV Positive | <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Stroke <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cancer <input type="checkbox"/> AIDS or HIV Positive |
| 3. | Do you or any of the family members to be covered have had any health covered have complaints/met with any accident & have been taking treatment/or hospitalised? Please provide details in the Annexure. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I have received FAQ document and have read it.

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want Group Health 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).

For complete details of Coverage & Policy Wording, kindly visit our website - www.sbigeneral.in

For Renewal of your Policy or for Cancellation of your Auto Renewal Authorisation please contact 1800-102-1111 / 1800-22-1111 (Toll-free 8:00 am to 8:00 pm - Monday to Saturday) or write to us at customer.care@sbigeneral.in.

ACKNOWLEDGEMENT SLIP (Tear Off):

Note: (1) You shall receive the Certificate of Insurance on receipt of your Proposal Form to the Head Office of SBI General Insurance Company. (2) Period of Insurance shall be 1 year from the date of transaction. (3) This acknowledgment slip does not in any way communicate the acceptance or commencement of risk under the application submitted by you. This is only an acknowledgment slip and is not the premium receipt. This acknowledgment 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. (4) Premium will be refunded in case your proposal is rejected by us. (5) For any assistance / clarification required kindly get in touch with SBI General Insurance Company Ltd. on 1800 22 1111, 1800 102 1111 (Toll Free). (6) For Renewal of your Policy or for Cancellation of your Auto Renewal Authorisation please contact 1800-102-1111 / 1800-22-1111 (Toll-free 8:00 am to 8:00 pm - Monday to Saturday) or write to us at customer.care@sbigeneral.in.

Disclaimer: SBI General Insurance Company Limited | Corporate & Registered Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai 400 099. | For more details on the risk factor, terms and conditions, please refer to the Sales Brochure and Policy Wordings carefully before conducting a sale. | For SBI General Insurance Company Limited IRDAI Reg. No. 144 dated 15/12/2009 | CIN: U66000MH2009PLC190546 | SBI Logo displayed belongs to State Bank of India and used by SBI General Insurance Company Limited under licence. | Group Health Insurance Policy UIN: SBIHLGP21330V022021 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

DECLARATION BY PRIMARY INSURED

1. I 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 am authorised to propose on behalf of these other persons. 2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable. 3. I further declare that I 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. 4. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time 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 insurer to whom 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 authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority." 6. I/we are aware of premium loading, (if any declared above)for habits & diseases as declared / mentioned by me /us above . 7. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance and ensure to provide the details of beneficiaries to the Company as and when required.

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

 Place: Signature of Proposer: _____

AGENTS 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, the Company shall have the right to vary the benefits which may be payable 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.

Licence No. _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

 Place: Signature of Agent: _____

NOMINATION (*Mandatory)

I _____ do hereby nominate Mr/Mrs/Ms _____ as the person & Mr/Mrs/Ms _____ as Guardian of the Nominee (in case Nominee is a minor) authorised to receive the amount payable by SBI General Insurance Co. Ltd. in the event of my death and He/She (Nominee) is related to me as _____ (Relationship with the Insured) and I further declare that his/her receipt shall be sufficient discharge to the Company.

Dated this _____ Day of _____ 20 _____ at _____

Address of the Nominee / Guardian: _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

 Place: _____
Signature of the Primary Insured

Name of the 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 (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

PREMIUM PAYMENT DETAILS

Journal Entry No.: _____ Journal Entry Date: _____ Bank A/c No.: _____
Premium Amount in Figures (including tax as applicable): _____ Amount in Words: _____
SBI Branch: _____ Branch Office Code: _____
Signed at: _____ Signature: _____ Authorised Signatory for SBI: _____

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 bonafide 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/We 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 statutes, directly or indirectly governing the prevention of money laundering in India.

Nationality: Indian _____ If Non-Indian, please specify the Country: _____

Type of Organisation:

- | | | |
|---|--|---|
| <input type="checkbox"/> Corporations | <input type="checkbox"/> Government | <input type="checkbox"/> Non- Governmental Organization |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Trust | <input type="checkbox"/> Society <input type="checkbox"/> NGO |
| <input type="checkbox"/> Politically exposed Parties^ | <input type="checkbox"/> International Organizations | <input type="checkbox"/> Cooperatives <input type="checkbox"/> Section 25 Companies |

^ Political expose parties (PEP'S)- Politically Exposed Parties are group of persons who are or have been entrusted with prominent public functions i.e., Heads / ministers of central or state government, senior politicians, senior government, judicial or military officials, senior executives of government companies, important party officials.