SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

ENROLMENT FORM

SBI GENERAL AROGYA GOLD-GROUP

GUIDELINES FOR THE COMPLETION OF THE FORM:

1. Please answer all questions fully and correctly. 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 on non-disclosure of 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 his behalf.
4. Kindly contact the Company's Office or Intermediary/Agents for any doubts or clarifications on the proposal form.
5. Information for fields marked with asterisk (*) is mandatory.

Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by SBI General Insurance Company Limited. ("Company").

FOR OFFICE USE ONLY

Quote Number: Inward Number:

Master Policy Number:

Receipt Number: Receipt Date: D D M M Y Y Y Y

Business Type: ☐ New ☐ Rollover ☐ Renewal ☐ Migration ☐ Portability

Business Sector: ☐ Rural ☐ Urban ☐ Social ☐ Others

INTERMEDIARY DETAILS* (Mandatory field if Sales channel type selected is Banca)

Branch Name: Branch Code:

Intermediary Name: First Name Middle Name Surname

Intermediary Code: Intermediary Contact Detail:

GSTIN/ISDN (If Applicable): IF APPLICABLE Specified Person's Code*/PF ID:

Sales Channel Type: ☐ Agency ☐ Direct ☐ Broker ☐ POS ☐ CSC ☐ Corporate Agent ☐ IMF ☐ Banca

POLICY DETAILS*

Policy Type: ☐ Individual ☐ Family Floater# Plan Name:

Policy Tenure: <<Years>> Sum Insured (in ₹):

Period of Insurance: Policy Start Date: D D M M Y Y Y Y Policy End Date: D D M M Y Y Y Y

Name of Organization/Institution: Branch of Organization/Institution:

#Floater Option will be applicable only for Hospitalization Cover.
Personal Accident/Cancer care cover will be available only on Individual Basis for Proposer/primary insured only.

Version: 1.0 May 2026

POLICYHOLDER/ PROPOSER DETAILS

Name of the Policyholder/ Proposer* First Name Middle Name Surname

Present Address* (Current Residing Address)

City: Village:

Gram Panchayat: State:

Pin-code: Landmark:

My Present Address is same as Permanent Address ☐

Permanent Address*

City: Village:

Gram Panchayat: State:

Pin-code: Landmark:

Contact Details*: Mobile No: Alternate Mobile No:

Email Address*:

Nationality*: ☐ Indian ☐ Non-Indian ☐ Non-residential Indian ☐ Others
(In case of Non-Indian, please provide nationality details)

PAN*: Form 97/98 (If PAN not available)

Aadhaar No.:

Passport/Driving License/Others:

Date of Birth*: D D M M Y Y Y Y Gender*: Male ☐ Female ☐ Other ☐

Marital Status*: ☐ Married ☐ Unmarried ☐ Divorced ☐ Widow(er)

Profession*: ☐ Salaried ☐ Self-Employed ☐ Any Other Details:_____

Occupation and Nature of Business/ Work*: Annual Gross Income (INR):

Total No. of Persons to be Covered*: GSTN/ISDN:

Bank Account Number/Customer ID:

As part of our Go Green initiative, your policy will be issued digitally to your registered mobile number via WhatsApp, SMS, and email. By issuing an e-policy, we help conserve the environment by saving a tree. An electronic policy document holds the same legal validity as a physical copy. The date on which the policy document is delivered will be considered for determining the free look period.
However, if you would prefer to receive a physical copy of your policy document, simply send an SMS with the message "PRINT <Policy Number>" to 561612 from your registered mobile number.

COVERAGE DETAILS*

Please refer to Annexure-A at the end of this form and choose the covers.

Insured Details	Insured 1	Insured 2	Insured 3	Insured 4
Name*				
Date of Birth*				
Gender*				
Height				
Weight				
Marital Status*				
Contact No.*				
Relationship with Proposer*				
Nationality (Indian/Non-Indian/ Non-resident Indian/Other)*				
Occupation*				
Monthly Income in Rs. (Mandatory if Personal Accident cover is opted)*		NA	NA	NA
Hospitalization cover Sum Insured* (in INR)				
Personal Accident Sum Insured (in INR)		NA	NA	NA
Cancer Care Sum Insured (in INR)		NA	NA	NA
ABHA (Ayushman Bharat Health Account) number (if available)#				

NOMINEE DETAILS

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4
Name of the Nominee*				
% Share of Claim Amount				
Date of Birth*				
Gender (M/F/O)*				
Relationship with Policyholder*				
Mobile No. of the Nominee*				
Present Address of the Nominee				
Permanent Address of the Nominee				
Nominee Email ID				
Name of A/C holder				
Account Number				
IFSC Code				
MICR Code				
Bank Name				

^(Please attach a separate sheet if required in case of multiple nominees)
*If Nominee is a minor, give the details of Appointee.

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4
Name of the Appointee*				
Date of Birth*				
Gender (M/F/O)*				
Relationship with Nominee*				
Mobile No. of the Appointee*				
Address of the Appointee				
Name of A/C holder				
Account Number				
IFSC Code				
MICR Code				
Bank Name				

MEDICAL & LIFESTYLE INFORMATION

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4
Name of Illness/Disease/ Accidental Injury				
Duration Since Suffering from				
Medications details (present/ past) please specify				
Are you fully cured (Yes/No)				
Differently Abled Status (Yes/No)				
Type of Impairment/ Disability				
Percentage of Impairment/ Disability				
UDID Number				

*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 officials senior executives of state-owned corporations and important political party officials.

PREMIUM PAYMENT AND BANK ACCOUNT DETAILS

Name of the A/c Holder: ☐

Premium Amount in ₹: ☐☐☐☐☐☐☐☐ Premium Amount: (in words)_____

Premium Payment Option: ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Annual

Instrument Type: ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others, Please Specify:_____

Card No. ☐ Card Expiry Date: D D M M Y Y Y Y Card Details: Master ☐ Visa ☐

Cheque Date: D D M M Y Y Y Y Cheque/Journal No.*: ☐☐☐☐☐☐

Bank Name: ☐ Branch Name: ☐

Bank Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ IFSC Code: ☐☐☐☐☐☐☐☐☐☐

ASBA Declaration:

☐ I hereby accord my consent to authorise SBI General Insurance to block the applicable premium payable for the aforesaid insurance policy under the BIMA ASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount

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

INSURED BANK DETAILS* (Claim/Refund amount will be deposited in this Bank Account only unless changed subsequently)

In case of cancellation of policy, if premium were paid through credit card the refund amount would be credited to your designated bank account. Please provide the following bank details and a copy of Cancelled Cheque: (Cancelled Cheque should be of the same bank account in which the refund/claim needs to be credited directly

Bank Name*: Branch:

Name as in Bank Account*:

Bank Account No.*: Cheque No.:

IFSC Code: MICR Code:

Note: The Proposer agrees and undertakes to intimate in writing to SBI General Insurance about any change in bank account details. If ECS is selected, please submit the standing instruction form available at our branches.

PREVIOUS/ EXISTING INSURANCE DETAILS

Insured Name	First Policy Inception Date	Period of Insurance (From & To)	Sum Insured	Claim Details (If Any)

DECLARATIONS ON BEHALF OF ALL PERSONS TO BE INSURED

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 authorized 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 of 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 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 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 authorize 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 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 an account holder and is not a third-party payment made by any other person on my/our behalf.
7) 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.
8) I declare that the details provided in the proposal form will be used for both new and renewal purposes.

Date: D D M M Y Y Y Y

Place:

Signature of Proposer

SBI general INSURANCE
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ELECTRONIC ACCOUNT DETAILS

I have an eIA Number: | | | | | | | | | | | | | |

I would like to apply for eIA with:

(a) NSDL Database Management Ltd. ☐

(b) Centrico Insurance Repository Limited (Formerly Known as CDSL Insurance Repository Limited). ☐

(c) Karvy Insurance Repository Ltd. ☐

(d) CAMS Insurance Repository Services Ltd. ☐

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.

Date: D D M M Y Y Y Y

Customer Name:_____

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

DECLARATION FOR UPDATE VIA DIGITAL MODE

☐ I/We acknowledge that by opting for digital services, I/We provide consent to receive communication/services related to my Insurance Policy and any additional information the insurer shall share related to products and services, including cross-sell and up-sell offerings, through my registered mobile number & email.

Date: D D M M Y Y Y Y

Place: | | | | | | | | | | | | |

Signature of Proposer

Renewal Payment Sign-Up:

Payment of renewal premium of your health insurance Policy can be made every year through continuing your existing Automated Clearing House (ACH) / Standing Instructions (SI) with the Company. Under this option, your Policy can be renewed promptly, but subject to you completing all additional requirements of information and documentation as may be required by the Company.

☐ **I want to opt for the ACH/SI renewal option.**

Date: D D M M Y Y Y Y

Place: | | | | | | | | | | | | |

Signature of Proposer

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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.

Residential Status: Resident Individual ☐ Non-Resident Indian ☐ Foreign National ☐ Person of Indian Origin ☐

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 ☐ Politically Exposed Parties^

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.

Signature of Proposer

^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.

AGENTS DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/Authorized 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.

Specified Person Name: _____

Specified Person Code: _____

License No.: _____

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

Signature of Proposer

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VERNACULAR DECLARATION

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) _____ (Relation with the Proposer/Primary insured) _____adult and inhabitant of (city) and residing at _____ do hereby certify that I 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 knowledge and belief.

Signature of the Witness Insured

Signature/Thumb impression of the Proposer/Primary.

Date: D D M M Y Y Y Y

Place:

INSURER DECLARATION

Note: The liability of the Company does not commence until the acceptance of the proposal has been formally intimated by the insured and full premium has been realized by the Company.
We are under no obligation to accept any proposal for Insurance. The Proposer agrees that the receipt of the Proposal Form by SBI General Insurance Company Limited along with the premium payment does not tantamount to the acceptance of the Proposal for Insurance by SBI General Insurance Company Limited and does not result in a concluded contract of Insurance. The acceptance of the Proposal for Insurance shall be at the Company's sole and absolute discretion and upon full realization of the premium payment. In the event of acceptance of the Proposal for Insurance by SBI General Insurance Company Limited, such acceptance shall be specifically intimated to the Proposal and SBI General Insurance Company Limited along with the date from which the Insurance cover shall become effective. SBI General Insurance Company Limited shall not be liable for any claim in respect of an event giving rise to a claim covered under the Policy of Insurance that has occurred prior to Policy issuance, not covered under this Policy (Your proposal form will be considered after SBI General Insurance Company Limited receives the premium payment.)

Sharing of Information: The information sought from the insured is for the purpose of policy issuance and policy servicing. This information sought and the details of policy are kept confidential and will not be shared with any external party in any circumstances whatsoever. However, in instances when such information/details are sought by any governmental bodies, regulatory authority's reinsurer or when the Company is directed to share such information in accordance with any law/regulations or direction from any such government bodies/regulatory authorities, the Company will be bound to abide to such directions.
Fraud Warning: This policy shall be voidable at the option of the Company in the event of misrepresentation, mis-description, or non-disclosure of any material particulars by the Proposer. Any person who, knowingly and with intent to fraud the insurance company or any other person, files a proposal for insurance containing any false information, or conceals or the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which will render the policy voidable at the sole discretion of the insurance company and result in a denial of insurance benefits.

SECTION 41 OF INSURANCE ACT, 1938

1) No person shall allow 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 or 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 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 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 to Ten Lakh rupees.

Annexure-A

Cover Section	Cover Name	Opted / Not Opted	Sum Insured/Limits
Hospitalization Cover	In-Patient Care	<Opted/Not Opted>	<Sum Insured>
	Day Care Treatment	<Opted/Not Opted>	Up to Hospitalization Cover SI
	Organ Donor Expenses	<Opted/Not Opted>	<As per limit chosen>
	In-Patient Care under Alternative Treatment (AYUSH)	<Opted/Not Opted> .	Up to Hospitalization Cover SI .
	Domiciliary Hospitalization	<Opted/Not Opted>	Up to Hospitalization Cover SI
	Pre-Hospitalization Medical Expenses	<Opted/Not Opted>	<30/60/90 days>
	Post-Hospitalization Medical Expenses	<Opted/Not Opted>	<60/90/180 days>
	Modern Treatment	<Opted/Not Opted>	<50/ 100% of Hospitalization Cover SI>
	OPD Cover .	<Opted/Not Opted> .	<As per limit chosen> Co-Payment- <Nil/10/20/30/40/50 %>
	Emergency Ground Ambulance	<Opted/Not Opted>	<As per limit chosen>
	Weekly Benefit	<Opted/Not Opted>	<As per limit chosen>
	Home Health Care	<Opted/Not Opted>	Up to Hospitalization Cover SI
	Common Disease Cover	<Opted/Not Opted>	<As per limit chosen>
	Health Check Up	<Opted/Not Opted>	<As per limit chosen>
	E-Opinion	<Opted/Not Opted>	Available
	Wellness	<Opted/Not Opted>	Available
Personal Accident	Accidental Death (AD)	<Opted/Not Opted>	<Personal Accident SI>
	Permanent Total Disability (PTD)	<Opted/Not Opted>	<Up to Personal Accident Sum Insured>
	Permanent Partial Disablement (PPD)	<Opted/Not Opted>	<Up to Personal Accident Sum Insured>
	Repatriation & Funeral Expenses	<Opted/Not Opted>	<As per limit chosen>
	Child Education	<Opted/Not Opted>	<As per limit chosen>
	Adaptation Allowance (Home & Vehicle)	<Opted/Not Opted>	<Rs 20,000, 25,000, 50,000>
	Ambulance Cover	<Opted/Not Opted>	<As per limit chosen>
	Broken Bones/ Fracture	<Opted/Not Opted>	<As per limit chosen> >
	Loss of Income .	<Opted/Not Opted> .	<As per limit chosen> Duration Option- <1 month to 12 months>
Cancer Care	Cancer Care Benefit	<Opted/Not Opted>	<Cancer Care / Cancer + Cardiac Care > <As per limit chosen> Survival Period- <0/7/14/28 days>

Room Rent	Actuals/Single Private AC Room

Waiting Period	Initial Waiting Period (Hospitalization cover)	30 days
	Specific Illness Waiting Period	12 months
	Pre-existing Disease Waiting Period	<12/24/36 Months>
	Cancer Care Waiting Period	<0/30/90/180 days>

Note: 1)All Sections are optional in nature. It is mandatory to opt one Section, however the covers offered under the Section can be opted as per Master Policyholder choice. 2) Section Personal Accident and Cancer Care are applicable for Proposer/ primary insured only.