PROPOSAL FORM

INDIVIDUAL PERSONAL ACCIDENT INSURANCE POLICY

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Information for fields marked with asterisk (*) are mandatory.

Guidelines for completion of the form: Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable. Kindly contact SBI General Office for any doubts or clarifications in the Proposal Form.

The liability of SBI General does not commence until this proposal has been accepted by SBI General and premium paid and upon full realisation of the premium payment by the Company, the acceptance of which shall be specifically intimated to the Proposer by the Company along with the date from which the Insurance Cover shall become effective and the Insurance Cover shall only be effective from the date as intimated by the Company.

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

Segment Type: ☐ Corporate ☐ Retail ☐ SME

Business Sector: ☐ Urban ☐ Rural ☐ Social ☐ Others

Business Type: ☐ New ☐ Renewal ☐ Migration ☐ Portability

Sales Channel Type: ☐ Agency ☐ Direct

Sales Channel Code:

Specified Person's Code*:

Specified Person's Name*:

GSTIN/ISDN: IF APPLICABLE

PROPOSER'S DETAILS*

1. Name of the Proposer*: F I R S T N A M E M I D D L E N A M E S U R N A M E
2. Relationship between the Proposer and the Insured Person*:
3. Present Address*: (Current Residing Address)

City: Village:

Gram Panchayat: State:

Pincode: Landmark:

My Present Address is same as Permanent Address ☐

Permanent Address*:

City: Village:

Gram Panchayat: State:

Pincode: Landmark:

4. Contact Details*: Mobile No.: Alternate Mobile No.:
5. Email*: 6. Nationality*:
7. Aadhaar ID No.: 8. PAN No.*: /Form 60/61.* (If PAN not available):
9. Passport/Driving License/ Voter ID:
10. Period of Insurance: From: D D M M Y Y Y Y To: D D M M Y Y Y Y
11. Profession/Occupation/ Trade or Business (Please describe fully with nature of duties):
12. Do you engage in racing on wheels or horseback, big game hunting, mountaineering, winter sports, skating or ice hockey, ballooning or polo or sports of similar nature? ☐ Yes ☐ No
13. Where does your average monthly come from:

Gainful Employment: Other Sources: Total in ₹:

Gross Annual Income in ₹:

14. Date of Birth: D D M M Y Y Y Y 15. Martial Status*: 16. Gender: Male ☐ Female ☐ Other ☐
17. Are you an employee of SBI Group Company? Yes ☐ No ☐

If 'Yes', please state the name of the company and employee code:

18. Is this proposal for insurance in addition to:

- Any other Accident Policy? (including if covered under any Group Personal Accident Policy/Credit Card Schemes) Yes ☐ No ☐

If so, give the name of each Company, Policy Number and Amount of Insurance_____

- Any other Employee Scheme? Yes ☐ ☐ No

If so, give the name of each Company and Amount of Insurance: _____

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19. Has any Company:

- Declined to issue a Policy to you? Yes ☐ ☐ No
- Declined to continue your Insurance? Yes ☐ ☐ No
- Imposed any restriction or special conditions? Yes ☐ ☐ No

If Yes, please furnish the details: _____

20. 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.

21. Corporate: Yes ☐ No ☐ 22. GSTIN/ISDN: IF APPLICABLE

The digital copy of your policy document in PDF format will be sent to the registered mobile number or registered email ID
However, if you need a physical copy of the policy document, please send SMS "PRINT <Policy Number>" to 561612 from your registered mobile number.

DETAILS OF THE PERSON PROPOSED TO BE INSURED (* Mandatory Fields)

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name*						
Date Of Birth*						
Gender*						
Marital Status*						
Occupation*						
Nationality* (Indian/ Non-Indian /Non-resident Indian/Other)						
Relationship with the Proposer*						
Basic Sum Insured*						
ABHA (Ayushman Bharat Health Account) number (if available):						

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)

Have you suffered or do you suffer from

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Any physical defect or infirmity	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Gout or Arthritis or Diabetes or Paralysis	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Fits of any kind or any other chronic disease	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Any other disability						
Type of Disability						
Percentage of Disability						

Please select the coverage:

Every member of the family has the option to choose any benefit from table A, B, C,D and the fixed Sum Insured. However the table of benefit opted by family members should not be more than the benefit chosen by the Primary Insured. Maximum Sum Insured is ₹1,00,00,000/- and the minimum Sum Insured is ₹1,00,000/-. Sum Insured for Accidental Death Benefit/Permanent Total Disability is limited to 120 times the monthly gross income or 10 times the annual gross earnings from gainful employment/ occupation. Sum Insured to dependent children, dependent parents, parents-in-law and unemployed spouse is limited to 20 % of Sum Insured of the Primary Insured or ₹10,00,000/- (whichever is less).

	Sum Insured Opted (Add sheet if columns are less)					
Benefit	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**
Table A - Accidental Death						
Table B - Accidental Death and Permanent Total Disablement (PTD)						
Table C - Accidental Death, (PTD) and Permanent Partial Disablement(PPD)						
Table D - Accidental Death, (PTD), (PPD) and Temporary Total Disablement						

- Permanent Total Disability (PTD) benefit comes with the following benefits at no additional cost.

- Education Benefit - Death & Permanent Total Disability claims entitle the Insured's child and spouse to Education Benefit to maximum two individuals (children/ spouse) on proof of enrolment at a Government approved education facility at ₹50,000/- or 1% of CSI (basic SI), whichever is lower for each child/spouse.

-Adaption Allowance - Permanent Total Disability claims also include payment towards cost of modifying the Insured's house or vehicle to combat disability @1 % or ₹25,000/- whichever is less.

Additional Covers (Please provide Sum Insured for the covers opted):

Benefit	Yes (Specify the limit)	No
Hospital Confinement Allowance The per day allowance is ₹ 1000 / 2000 / 3000/- with a maximum coverage for 15 days for the entire policy period (If You are admitted in a Hospital due to Injury or Accident that occurs within the Republic of India.)	₹ 1000 / 2000 / 3000	
Ambulance including Air Ambulance Sum Insured @ 10% subject to a maximum of ₹ 1,00,000/- per Policy Period towards expenses incurred for availing an Ambulance Service [Expenses incurred for availing an Ambulance Service (including Air Ambulance) to transfer the Insured Person to a hospital from the location of Accident or Injury or from one hospital to another hospital or from hospital to the place of residence in case of death or PTD. The ambulance service will be for the transit within India only.] Ambulance cover available only when AD Sum insured is ₹ 5,00,000 and more.	Write Yes if opted	

NOMINEE DETAILS*

Insured Name	Insured 1			Insured 2			Insured 3		
Nominee details	Nominee 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3
Name of the Nominee*^									
% share of Claim Amount									
Date of Birth (DD/MM/YYYY)*									
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									
Branch Name									

Insured Name	Insured 4			Insured 5			Insured 6		
Nominee details	Nominee 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3
Name of the Nominee*^									
% share of Claim Amount									
Date of Birth (DD/MM/YYYY)*									
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									
Branch Name									

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

Appointee Details						
Insured Name	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**
Name of Appointee*						
Date Of Birth (DD/MM/YYYY)*						
Gender (M/F/O)						
Relationship with Nominee*						
Address of Appointee						
Appointee Mobile no*						
Name of A/C holder						
Account Number						
IFSC Code						
Bank Name						
Branch Name						

In the event of death of the proposer, any payment due under the policy shall become payable to the nominee in accordance with the policy terms and conditions. Nominee for self, must be an immediate relative of proposer. (Please attach a separate sheet if required).

MEDICAL AND LIFE STYLE INFORMATION:

Has any of the persons proposed to be insured ever suffer from / are currently suffering from any of Illness/ diseases or any pre-existing accidental injury? [If answer is Yes, then please specify the details in below table and attach relevant medical reports from Medical Practitioner if any].

Insured Name	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**
Name of Illness/disease/Injury/ Disability:						
Duration since suffering from:						
Type of disability						
Percentage of disability						
Medications details (present/ past) please specify:						
Are you fully cured- Yes/No?						

PREMIUM PAYMENT DETAILS*

Name of Premium payor: 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

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

Premium Amount: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Cheque No./DD No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date: D D M M Y Y Y Y Instrument Type: ☐ Cheque ☐ Debit Card ☐ Credit Card Others: Please Specify: _____

Bank Name:

Bank Account Number: IFSC Code:

Branch Name:

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.

SBIGI 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*: Bank Name*:

Name as in Bank Account*:

Bank Account 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.

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

AML GUIDELINES*

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

Type of Organisation:

☐ 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:

DECLARATION

1. I/We hereby declare on my behalf and on behalf of all the 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/We am/are authorised to propose on behalf of these other persons.
2. I/We 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 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 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 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 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
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.
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:

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) _____ (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.

_____	_____
Signature/Thumb impression of the Proposer	Signature of the Witness

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

Insurance is subject matter of solicitation.

AML Declaration as per AML Master Guideline 2022:

1. KYC Details for Individual Members covered under the Group Insurance:

   "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."

   To be included as declaration by proposer /insured Section in all Proposal forms.

2. Please note, in absence of PAN, kindly provide Form 60/61 (irrespective of premium amount).

Applicable to non Individual customers.

3. 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 or who exercises control through other means.

Explanation - For the purpose of this clause, "Control" shall include the right to control the management or policy decision

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.