

HEALTH INSURANCE POLICY-RETAIL

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

Quote No.:
 Inward No.:
 Receipt No.:
 Receipt Date:

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

PART I - PROPOSER (* Mandatory Fields)

1.* Do you have existing relationship with SBI General Insurance? Yes No If Yes, then please mention the Customer ID:
 2.* Title: Mr. Miss Mrs. 3.* Name:
 4.* Gender: Male Female Other 5.* Date of Birth:
 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. Aadhaar Card No.:
 9.* Occupation: Salaried Self Employed/ Professional Business Student Retired Agriculture & allied Others (specify _____)
 10. Email Address: PAN: / Form 60/61:
 11. Tel. Details: Landline No.: Mobile No.*:
 12.* Preferred Contact Mode (Please Tick ✓): Email Paper Mail Phone 13. Preferred Payment Mode: EFT Cheque
 14. Period of Insurance: From To 15. Marital Status: Married Single
 16.* Proposer's Permanent Residential Address:
 City: Pincode:
 17. Nominee's Name:
 18. Nominee's Date of Birth: 19. Nominee's Relationship with the Primary Insured:
 20. Appointee's Name: 21. Appointee's Relationship with Nominee:
 22. Are you one among the Insured Persons Covered below? Yes No

23. Details of Persons/Members proposed for Insurance:

| Details | Primary Insured | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 |
|-------------------|-----------------|-----------|-----------|-----------|-----------|-----------|
| Name: | | | | | | |
| Gender: M/F/Other | | | | | | |

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. | Health Insurance Policy - Retail UIN: SBIHLIP22138V042122 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

| Details | Primary Insured | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 |
|----------------------------------------|-----------------|-----------|-----------|-----------|-----------|-----------|
| Date of Birth (DD/MM/YYYY): | | | | | | |
| Relationship with the Proposer: | | | | | | |
| Relationship with the Primary Insured: | | | | | | |
| Height (in Metres): | | | | | | |
| Weight (in Kilograms): | | | | | | |
| Occupation: | | | | | | |
| Gross Monthly Income: | | | | | | |
| Benefit Amount/Sum Insured: | | | | | | |
| Marital Status: | | | | | | |
| Educational Qualification: | | | | | | |

If any of the individual proposed for cover are not Covered earlier but are being proposed now? Yes No

DETAILS OF COVER SOUGHT:

Note: By Family we mean You, Your legal Spouse, Legal & Dependent Children

| | | | |
|--------------------|-------------------------------------|-------------------------------------------------|-----------------------------------------|
| Sum Insured Option | <input type="checkbox"/> Individual | <input type="checkbox"/> Individual with Family | <input type="checkbox"/> Family Floater |
| Plan | <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan B | <input type="checkbox"/> Plan C |

ADD-ON COVERS:

(1) Removal of Room & ICU rent sub limits? Yes No (2) Removal of sub limits on operation and consultancy charges? Yes No

24. Are You or any of the proposed applicants are Politically Exposed Person? Yes No

Politically Exposed Persons (PEP) are individuals 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.

25. Corporate

Yes No

26. GSTIN/ISDN:

IF APPLICABLE

PART II - OTHER / CURRENT HEALTH INSURANCE INFORMATION

IMPORTANT NOTE: Please provide details of any Individual 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.

- Do you hold or have any other Health Insurance Policies other than the one being proposed now, either with us or with other Insurers covering the Individuals proposed for Insurance now? Yes No
- If any of the individual proposed for cover are not covered earlier but are being proposed now, please provide full details of the same.

| Name of the Individual | Date of birth | Relationship with the Primary Insured |
|------------------------|---------------|---------------------------------------|
| | | |

3. If the answer to (1) is Yes, please provide the details of the Policies including details thereof in the below table and also provide complete details about the Individuals not covered earlier but are being provided now as in a separate page/sheet.

| Year | Insurance Company's Name | Policy No. | Period of Insurance | Sum Insured | Special terms of Acceptance/Exclusion under Policy (if any) | Cumulative Bonus % & Amount in ₹ | Claims Received/Receivable (₹) & the Name of the Individual against whom the Claims are made |
|------|--------------------------|------------|---------------------|-------------|-------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------|
| | | | | | | | |

PART III - PERSONAL HEALTH DETAILS (To be filled in respect of all the Members Proposed to be covered under the Policy)

| Sr. No. | Details | Primary Insured | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 |
|---------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------|-----------|-----------|-----------|-----------|
| 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: 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? | | | | | | |
| 2c | 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? | | | | | | |

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| Sr. No. | Details | Primary 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, Epilepsy 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 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.

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

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

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

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

Instrument Type: Cash/ Cheque/ Debit Card/ Credit Card

Cheque No./DD No.: Amount: Date:

Bank Name: Branch:

Bank Account No.*: IFSC Code*:

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 of the Witness

Date:

Place:

Signature/Thumb impression of the Proposer/Primary Insured

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 statutes, directly or indirectly governing the Prevention of Money Laundering in India.

Nationality: Indian/Non-Indian

If Non-Indian, please specify the Country: _____

Type of Organisation: Corporation Government Non-Governmental Organisation Society Trust

(Only applicable if policy issued on Group Basis) Partnership International Organisation Cooperative Section 8 Companies

I hereby declare that the current address is different from the available 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 :

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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: _____

PART III - 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: _____

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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