PROPOSAL FORM

AROGYA TOP UP POLICY

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

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 Proposer 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 Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material particular to the proposal form/ personal statement, declaration and connected documents or any material information having been with held by the Proposer or anyone acting the on Proposer's behalf.
4. Kindly contact SBI GENERAL Offices or Agents for any doubts or clarifications on the proposal form.
5. Company may ask for the PAN of the Proposer in case the premium is more than ₹50,000.
6. Information for fields marked with asterisk (*) are mandatory.

Important Information: Health Check-Up/ Medical Examination may be required for all persons aged 55 years and above, and pre-acceptance medical tests is 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.

OFFICE USE ONLY

Branch Office Code: Branch Name:

Business Type: ☐ New ☐ Renewal ☐ Migration ☐ Portability

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

Business Sector: ☐ Urban ☐ Rural ☐ Social ☐ Others

INTERMEDIARY DETAILS*

Intermediary Name: SURNAME MIDDLENAME FIRSTNAME

Intermediary Code: Intermediary Contact Details:

PROPOSER'S DETAILS (* Mandatory Fields)

1. Name of the Proposer*: SURNAME MIDDLENAME FIRSTNAME

Gender*: ☐ Male ☐ Female ☐ Others Date of Birth*: DD MM YYYY

Marital Status*: ☐ Single ☐ Married ☐ Others Profession: ☐ Salaried ☐ Self-Employed ☐ Any Other Details: _____

Occupation and Nature of Business/ Work*: _____

2. Present Address*: (Current Residing Address)

City: Village:

Gram Panchayat: State:

Pincode: Landmark:

My Present Address is same as Permanent Address ☐

3. Permanent Address*:

City: Village:

Gram Panchayat: State:

Pincode: Landmark:

4. Contact Details*: Mobile No.: Alternate No.:

5. Email ID*:

5. Nationality*: ☐ Indian ☐ Non-Indian ☐ Non-Residential Indian (In case of Non-Indian, please provide nationality details) _____

6. Total No. of Persons to be covered*:

7. Are you one among the Insureds Covered below?* ☐ Yes ☐ No

8. Aadhaar Card No.: 9. PAN No*.: /Form 60/61* (If PAN not available): ☐

10. Passport/Driving License/ Voter ID:

11. Corporate*: ☐ Yes ☐ No 12. 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.

12. Are you or any of the proposed applicant*_____, please tick whichever is applicable: ☐ Yes ☐ No

HNI ☐ Jeweller ☐ NGO ☐ Film Actor/ Producer ☐ PEP ☐

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.

DETAILS OF COVERAGE SOUGHT*

Note: By Family we mean You, Your legal Spouse, Legal & Dependent Children, Dependent Parents and Parents-in-law (Parents, Parents-in-law, cannot be covered under Family Floater).

Policy Term (Please tick)	☐ 1 Year	☐ 2 Years	☐ 3 Years
Type of Policy (Please tick)	☐ Individual	☐ Family Non-floater	☐ Family Floater
Deductible (Please specify):			

Do you want to reinstate Sum Insured? ☐ Yes ☐ No Policy Period*: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

NOMINEE DETAILS*

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of the Nominee*^						
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						
Branch Name						

*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*						
Gender (M/F/O)						
Relationship with Nominee*						
Address of Appointee						
Appointee Mobile no*						
Name of A/C holder						
Account Number						
IFSC Code						
MICR Code						
Bank Name						
Branch Name						

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION*

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

I would like to apply for eIA with:

☐ NSDL Database Management Ltd. ☐ Centrico Insurance Repository Limited (Formerly Known as CDSL Insurance Repository Limited). ☐ Karvy Insurance Repository Ltd. ☐ 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.

Customer Name:_____ Date: D D M M Y Y Y Y

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

MEMBERS PROPOSED FOR INSURANCE (* Mandatory Fields)

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name*						
Gender*						
Date of Birth (DD/MM/YYYY)*						
Marital Status*						
Relationship with the Proposer*						
Occupation and Nature of Business/ Work*						
Nationality * (Indian/ Non-Indian/ Non-Resident Indian/ Others). In case of Nationality other than Indian, please provide details						
Basic Sum Insured* (Separate only for Individual cover)						
Other Insurance* ☐ Yes ☐ No						
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)

PREVIOUS / EXISTING INSURANCE

Are you applying for portability / Migration: ☐ Yes ☐ No

(If "Yes", please fill the separate portability from also)

Does any person to be insured presently hold any Health Insurance / Critical Illness Insurance Policies with SBIG or any other insurer?

☐ Yes ☐ No If Yes, then provide below details

Previous / Existing Insurance Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Policy Number						
Insurer's Name						
Period of Insurance						
Sum Insured (in Rs.)						
Claim Details (if any)						
Cumulative Bonus (if any, in Rs.)						

MEDICAL AND LIFE STYLE INFORMATION

If answer is Yes, then please specify and attach the relevant medical reports from Medical Practitioner if any, Has any of the persons proposed to be insured ever sufferd from/are currently suffering from of the illnesses/ diseases or any pre-existing accidental injury?

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you consume any of the following substances?

Sr	Substance	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2	Smoking	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3	Pan Masala /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4	Gutkha Any Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	substance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PAYMENT DETAILS*

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

Instrument Type: ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ DD ☐ EFT EFT No.:

Card Details: Card No.: Expiry Date: M M Y Y

Cheque No./DD No.: Amount: Date: D D M M Y Y Y Y

Bank Name: Branch:

Bank Account No.*: IFSC Code*:

Period of Insurance: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

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*: Branch:

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

Nationality: Indian ☐ Non-Indian ☐ Non-resident Indian(NRI) ☐ Others ☐

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 8 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 :

AGENT 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.

Agent Name: | | | | | | | | | | | | | | |

SP Name: | | | | | | | | | | | | | | |

SP Code: | | | | | | | | | |

License No.: | | | | | | | | | |

Date: D D M M Y Y Y Y Place: _____ Signature of Agent: _____

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 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.
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: _____

Name of the Proposer: _____

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 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 declare that whatever I 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

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 to Ten Lakh rupees.