

Health Edge Insurance

Important Guidelines

1. Please answer all questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.
2. Kindly contact the Company's Offices or Intermediary for any doubts or clarifications on the proposal form.
3. 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").
4. Information for fields marked with asterisk (*) are mandatory.
5. Only Resident of India with Indian Nationality/Citizenship can be covered under this policy.
6. Maximum four Adults can be covered under policy for the both Individual and Family Floater Policy type.
7. Proposer shall be Mandatorily covered as an Insured Person.

Office Use Only

Branch office Code:

Branch Name:

Business Type: New Roll-Over Renewal Migration

Sales Channel Type: Digital

Intermediary

Intermediary Name:

Intermediary Code:

Intermediary Contact Details:

Proposer Details (* - mandatory)

Name of the Proposer*:

Address*:

City: State:

Pin-Code: Landmark:

Phone No.: Alternate Contact No.:

Date of Birth*: PAN No*.: / Form 60/61:
(if Available):

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

Period of Insurance: From: to

Marital Status*: Married Unmarried Divorced Widow(er) Gender*: M F O

AADHAAR No. / Passport / Driving License/ Voter Id:

Profession: Salaried Self-Employed Any Other Detail

Occupation and Nature of Business/ Work*: Corporate: Yes No

Annual Gross Income: Email ID:

Total No. of Persons to be covered: GSTN/ISDN:

Are You or any of the proposed applicants or close relatives is/are associated to 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.

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 | Health Edge Insurance UIN: SBHILIP23173V012223 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

Are You Employee of SBI Group of Company? Yes No

If Yes, then mention Name of Group and Employee Number

Policy Details:

Policy Type*: Individual Floater Policy Period*: 1 Year 2 Years 3 Years

Policy Period: From: to

SUM INSURED (IN Rs.) PLEASE TICK (✓)*

Plan Name	Sum Insured		
Health Edge Insurance	3 Lacs <input type="checkbox"/>	5 Lacs <input type="checkbox"/>	7 Lacs <input type="checkbox"/> 10 Lacs <input type="checkbox"/> 15 Lacs <input type="checkbox"/> 20 Lacs <input type="checkbox"/> 25 Lacs <input type="checkbox"/>
No. of Days of Hospitalization covered	5 days <input type="checkbox"/>	10 days <input type="checkbox"/>	Unlimited <input type="checkbox"/>
Optional Covers Cover Required/Limits Opted/Sum Insured / Sub Limit (if yes, tick the limits required)			
Domestic help Indemnity (1A)	Yes <input type="checkbox"/> No <input type="checkbox"/>	if Yes, Number and Details of Domestic Help/Staff _____ Rs. 50,000 <input type="checkbox"/> Rs. 100,000 <input type="checkbox"/>	
Hospital Daily Cash	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rs. 1000 / 10 days <input type="checkbox"/>	Rs. 2000 / 10 days <input type="checkbox"/>
Accidental Death Cover - Primary Insured	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rs. 10,00,000 <input type="checkbox"/>	Rs. 20,00,000 <input type="checkbox"/>
Healing Benefit (>5 days of Hospitalization)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rs. 5,000 <input type="checkbox"/>	Rs. 10,000 <input type="checkbox"/>
Unlimited Refill (Related and Unrelated Illness both)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Vector Borne Fixed Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rs. 50,000 <input type="checkbox"/>	Rs. 100,000 <input type="checkbox"/>
Critical Illness Cover	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Claims Safeguard	Yes <input type="checkbox"/> No <input type="checkbox"/>		
OPD Cover (Rs .5000/Member)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Booster Benefit (reduction is same proportion in case claim is settled) (50% of Base Sum Insured up to 200% of Base Sum Insured)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
E-opinion	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Women Care Benefit^ Maternity Expenses (Normal Delivery – 25000 and C-Section 50000) New Born Baby Cover (Covered up to Sum Insured)	Insured 1	Insured 2	Insured 3
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Assisted Reproduction Treatment (Up to Rs 1,00,000)	Insured 1	Insured 2	Insured 3
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Global Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>		

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Wellness Benefit (Health Assistance (A.I. Personal Fitness coaching), Dietician and Nutrition E-consultation, Unlimited Gym membership)	Yes <input type="checkbox"/> No <input type="checkbox"/> If wellness is opted as Yes above, chose from below option for Unlimited Gym membership: Option 1 (3+3+3+3) <input type="checkbox"/> Option 2 (6+6)
Walk Healthy Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>
Co-payment	Yes <input type="checkbox"/> No <input type="checkbox"/> 10% <input type="checkbox"/> 20% <input type="checkbox"/>

Please Note- Women Care Benefit is applicable only for Adult Female Insured Person.

Please Note- Assisted Reproduction Treatment is applicable for only for Adult Insured Person and not applicable for Parents/Parent-In-law

Details of the Person Proposed to be Insured:

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name*						
Date of Birth (DD/MM/YYYY)*^						
Age*						
Gender*						
Marital Status*						
Height (in cms) *						
Weight (in Kgs) *						
Nationality*	Indian National / Indian Citizen	Indian National / Indian Citizen	Indian National / Indian Citizen	Indian National / Indian Citizen	Indian National / Indian Citizen	Indian National / Indian Citizen
Occupation and Nature of Business/ Work*						
Relationship with the Proposer*						
Basic Sum Insured (Separate only for Individual cover)						

^Please note: If the child above 18 years of Age is financially independent, he or she shall be ineligible for coverage under this Policy in the subsequent renewals. In case, policy is proposed for more than 6 Insured persons, kindly fill the details in an annexure.

Nominee Details:

In the event of death of the proposer, any payment due under the policy shall become payable to the nominee and the receipt of the proceeds by such nominee would be sufficient discharge to the company. For all other persons covered under the policy, the proposer will be the nominee. Nominee must be immediate relative (Mother, Father, Spouse, Son, and daughter) of proposer.

Nominee Name	Nominee Relationship	Nominee Age

Where Nominee is a minor, give the details of Appointee

Name of the Appointee	Relationship with Nominee	Address of Appointee

Previous / Existing Insurance:

Are you applying for portability / Migration: Yes No (If "Yes", please fill the separate portability form also)

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Nature of Duty				
Occupation				
Sum Insured (50,000/1 Lakh) PLEASE TICK (✓)	<input type="checkbox"/> 50,000 <input type="checkbox"/> 1 Lakh	<input type="checkbox"/> 50,000 <input type="checkbox"/> 1 Lakh	<input type="checkbox"/> 50,000 <input type="checkbox"/> 1 Lakh	<input type="checkbox"/> 50,000 <input type="checkbox"/> 1 Lakh
Place				
Date				
Signature/Thumb impression of the Proposed Insured (Domestic help/staff)				

Proposer Declaration:

I _____ (Full Name) of _____ (current residential address) hereby solemnly declare that I will be availing the services of the Domestic help(s)/staff(s) whose details are set out hereunder,

Date:

Place:

Signature of Proposer

Details of the Family Doctor:

Name of the Doctor:

Mobile No. or Contact No.:

Register No. of the Family Doctor:

Premium Payment and Bank Account Details:

Premium Amount: (in figure) ₹ (in words)

Name of Premium payor:

Premium Payment Frequency: Monthly Quarterly Half Yearly Annual Premium Single Premium

Premium Payment Options: Cash Cheque DD Debit Card/Credit Card Cheque No.:

Bank Name:

Amount: Date: Card Expiry Date:

Bank Account Number: Card Type: Master Visa

IFSC Code: Card No.:

Branch Name: Relationship with Proposer _____

Bank account Details for Process of Refund:

Cheque will be issued in the name of the Proposer only.
In case of cancellation of policy, if premium were paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account: (Cancelled Cheque should be of the same bank account in which the refund / claim needs to be credited directly.)

Cheque No.: Cheque Date: Amount for ₹

Bank Name: Branch Name:

Name of A/c. Holder: IFSC Code:

Bank Account No: 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.

Place : _____

Electronic Insurance Account Details:

I would like Health Edge Insurance and related information in

Physical Format- Yes No e-Format (electronic) as & when applicable- Yes No

I would like to apply for eIA with

(a) NSDL Data Management Ltd. (b) CDSL Insurance Repository Ltd.

(c) Karvy Insurance Repository Ltd. (d) 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):

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

Declaration for Update via Digital Mode:

"I/We acknowledge that by opting for digital services (including WhatsApp), I/We provide consent to receive communication/services from SBI General Insurance Company Limited related to my insurance policy through my registered mobile number & email".

Date:

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:

Place:

Signature of Proposer

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 statues, 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 (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 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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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 Proposer 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 is not covered under this policy (Your proposal form will be considered after SBI General Insurance Company Limited receives premium payment.)

Declarations on Behalf of all Persons Proposed to be 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 authorized 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 aware of premium loading, (if any declared above) for diseases as declared / mentioned by me or 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:

Place :

Signature of Proposer

Proposer Declaration:

The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract.

Date:

Place :

Signature of Proposer

Additional Declarations Pertaining to Wellness Benefits#:

I / We agree that on the issuance of the Policy, I / We will provide the Company with all relevant details relating to the tracking device and / or mobile app downloaded at the earliest. I / We understand and agree that these details are required by the Company for the Company to track, record and calculate my / our eligibility for the Wellness Benefits under the Policy. I / We declare and consent through my / our own free will and without any duress that the Company may access and record these details on a periodic basis and use these details for calculating and according the Benefits under the Policy. I / We further declare and consent that the original reports pertaining to any health assessments or tests undertaken by me / us in order to determine the eligibility to avail or continue to avail the Wellness Benefits under the Policy will be handed over by the concerned network providers directly to the Company and will remain on the Company's records.

Date:

Place :

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:

Place:

Signature of Agent

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:

Place:

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 authorities 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 punishable with fine, which may extend to Rupees Ten Lakhs.

Insurance is subject matter of solicitation.

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