





Major Illness Benefit		100% of Sum Insured maximum up to ₹25,00,000/-
Additional Sum Insured for Accidental Hospitalization		1.5X <input type="checkbox"/> 2X <input type="checkbox"/> of the Basic Sum Insured
Enhanced Cumulative Bonus		PRO 25% up to a Maximum of 200%
		PLUS / PREMIUM 50% up to a Maximum of 200%
NCB Protector		If claim is less than ₹50,000/- We will protect NCB% at the time of Renewal of Policy with Us
Co-Payment		10% <input type="checkbox"/> 20% <input type="checkbox"/>
Any Room Upgrade (Upgrade to any room excluding a suite and above)		PRO (applicable to ₹5 Lacs Sum Insured) <input type="checkbox"/>
		PLUS ₹6 Lacs to 20 Lacs <input type="checkbox"/>
		PREMIUM Not applicable <input type="checkbox"/>
Deductible		₹10,000 <input type="checkbox"/> ₹25,000 <input type="checkbox"/>

### 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*						
Age*						
Gender*						
Marital Status*						
Occupation*						
Nationality* (Indian/ Non-Indian/ Non-resident Indian/Other)						
Relationship with Proposer*						
Basic Sum Insured*						
ABHA (Ayushman Bharat Health Account) number (if available)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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](http://www.healthid.ndhm.gov.in)

**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)

### Nominee Details\*:

In the event of death of the Insured Person any payment due under the policy shall become payable to the nominee in accordance with the policy terms and conditions. Nominee must be immediate relative (Mother, Father, Spouse, Son, and daughter) of the proposer.

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Name	Contact Details	Date of Birth	Gender	Relationship with Proposer								
		<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>	
D	D	M	M	Y	Y	Y	Y					

Where Nominee is a minor, give the details of Appointee

Name of the Appointee	Relationship with Nominee	Appointee Contact details

### Previous / Existing Insurance:

Are you applying for portability / Migration: Yes  No

(If "Yes", please fill the separate portability form 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						
Premium Paid (Rs)						
Claim Details (if any) Incurred Claim (Outstanding + Received): Claim Ratio (%):						

### 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 suffered from/ are currently suffering from any of the illnesses/ diseases or any pre-existing accidental injury?

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Smoking	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Pan Masala /Gutkha	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Any Other substance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Insured details	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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### Additional Medical History (If Any):

(Describe complete details of disease, Surgery if any, Disability %, Date of diagnosis, Details of treatment) \_\_\_\_\_

### Details Of The Family Doctor:

Name of the Doctor:

Mobile No.:  Contact No.:

Registration No. of the Family Doctor:

### Premium Payment And Bank Account Details\*:

Cheque/Journal No.:  Cheque Date:  Amount for ₹

Bank Name:  Branch Name:

Name of the A/c. Holder:  IFSC Code:

Bank Account No.:  MICR Code:

Premium Amount: (in words) \_\_\_\_\_

Premium Payment Option: Monthly  Quarterly  Half Yearly  Annual  Single Premium

Premium payment mode option: Cheque  DD  Debit Card / Credit Card

Card Details: Master  Visa  Card No.  Card Expiry Date:

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

### 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 was 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.)

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.

### Electronic Insurance Account Details:

Choose your Insurance Repository (For those selecting e-Format)

- (a) NSDL Data Management Ltd.  (b) CDSL Insurance Repository Ltd.
- (c) Karvy Insurance Repository Ltd.  (d) CAMS Repository Services Ltd.

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

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:

Kindly visit our website [www.sbigeneral.in](http://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 (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 the Insured

### 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:

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 statutes, 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 25 Companies

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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

### 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.

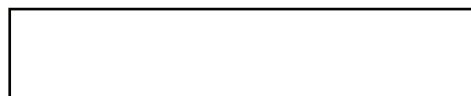
We are under no obligation to accept any proposal for Insurance. The Proposer agrees that the receipt of the Proposal Form by SBI General Insurance Company Limited along with the premium payment does not tantamount to the acceptance of the Proposal for Insurance by SBI General Insurance Company Limited 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 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.)

### 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
6. I/we aware of premium loading, (if any declared above) for habits & 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 the Insured

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## 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 the 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 which 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 furthermore 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.

License No.: \_\_\_\_\_

Date:

Place:

Signature of the 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) \_\_\_\_\_ (relationship 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 my/our knowledge and belief.

Signature of the Witness Insured

Date:

Signature/Thumb impression of the Proposer/Primary.

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 the 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 directions 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 mis-representation, 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 for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, It 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:

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.

Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Rupees Ten Lacs.

Insurance is subject matter of solicitation.

**AML Declaration as per AML Master Guideline 2022:**

1. 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.**
- 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.

Date:

Signature of Policyholder: