PROPOSAL FORM

Divyanga Suraksha, SBI General Insurance

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

GUIDELINES FOR COMPLETION OF THE FORM:

1. This policy is specially designed for Persons with Disability, Mental illness and Persons with HIV/AIDS.
a. Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability Act 2016.
2. Please answer all questions correctly and completely.
3. Information for fields marked with asterisk (*) are mandatory.
4. Only Indian Nationals can be covered under this policy.
5. Only one policy can be purchased for this product across all insurers.

Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by Name of the Insurance Company.

INTERMEDIARY DETAILS

Intermediary Name*:

Intermediary Code*:

Intermediary Contact Details*:

Business Type: New ☐ Renewal ☐ Migration ☐ Portability ☐ Business Sector: Urban ☐ Rural ☐ Social ☐ Others ☐

PROPOSER DETAILS (* Mandatory Fields)

1. Bank Account No.*:
2. Primary Insured's Name*: SURNAME MIDDLENAME FIRSTNAME
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:

Nationality*:

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

PAN No.*.: / Form 97/98 (If PAN not available): ☐ Aadhaar No.:

Passport/Driving License/Voter ID:

Date of Birth*: DD MM YYYY E-mail ID*:

Profession*: Salaried: ☐ Self Employed: ☐ Any Other: _____ Gender*: M ☐ F ☐ Other ☐

Occupation and Nature of Business/ Work: _____

Period of Insurance*: From DD MM YYYY to DD MM YYYY

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.

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

COVERAGE DETAILS:

Policy Type*	Individual Basis
Policy period*	1 year
Period of Insurance*	From DD MM YYYY to DD MM YYYY
Sum Insured*	400000 ☐ 500000 ☐

Version: 1.0 Mar 2026

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 license. | Divyanga Suraksha, SBI General Insurance, UIN: SBIHLIP23191V012223 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

Call (Toll Free) | 1800 22 1111 | 1800 102 1111 | www.sbigeneral.in

URN: SBIG/DS/V.04/15072025

Coverage opted*:	Pre-existing HIV/AIDS	☐
	Pre-existing Disability	☐
	Pre-existing HIV/AIDS and Disability	☐
Waiver of Co-payment opted*	Yes ☐	No ☐

DETAILS OF PERSONS TO BE INSURED*

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of the Insured*						
Sum Insured*						
Date of Birth*						
Age*						
Gender*						
Height*						
Weight*						
Occupation*						
Nationality* (Indian/ Non-Indian/ Non-resident Indian/ Other)						
Marital Status*						
Relationship with Proposer*						
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)

NOMINEE DETAILS*

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of the Nominee*^						
Date of Birth*						
Age*						
Gender (M/F/O)						
Relationship with Policyholder*						
Mobile No. of the Nominee*						
Permanent Address						
Present Address						
Nominee Email ID						
Name of Account holder						

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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 Account holder						
Account Number						
IFSC Code						
MICR 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).

PREVIOUS/EXISTING HEALTH DETAILS OF INSURED:

Do you suffer from HIV/AIDS? If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)	☐ Yes ☐ No
Current CD 4 count	
Has your CD4 Count gone below 500 in the past 4 years? If yes when and How many times	☐ Yes ☐ No
Do you suffer from any other illness/ disease related to/ arising of/ associated to HIV/AIDS? If Yes, please give details:	☐ Yes ☐ No
Do you suffer from any disability as per the listed conditions mentioned below: If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable. ☐ Blindness ☐ Muscular Dystrophy ☐ Low vision ☐ Chronic Neurological conditions ☐ Leprosy Cured persons ☐ Specific Learning Disabilities ☐ Hearing Impairment (deaf and hard of hearing) ☐ Multiple Sclerosis ☐ Locomotor Disability	☐ Yes ☐ No
☐ Speech and Language disability ☐ Dwarfism ☐ Thalassemia ☐ Intellectual Disability ☐ Haemophilia ☐ Mental Illness ☐ Sickle Cell disease ☐ Autism spectrum disorder ☐ Multiple Disabilities including deaf/ blindness ☐ Cerebral Palsy ☐ Acid Attack victim ☐ Parkinson's disease	
Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? If Yes, please specify details and the number of years you are suffering:	☐ Yes ☐ No
Do you have any other physical disability arising out of any illness / disease condition?	
Any other previous medical details	

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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	Policy Number	Insurer's Name	Period of Insurance	Sum Insured	Premium Paid (Rs)	Claim Details (if any) Incurred Claim (Outstanding+ Received): Claim Ratio (%):
Insured 1						

ELECTRONIC INSURANCE ACCOUNTS DETAILS*

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 ☐

CKYC No (Central Know Your Customer Registry Number), (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).

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	Name of Illness/ Disease/ Accidental Injury	Duration Since Suffering from	"Medications details (present/ past) please specify"	Are you fully cured (Yes/No)	Differently Abled Status (Yes/No)	Type of Impairment	Percentage of Impairment	UDID Number
Insured 1								
Insured 2								
Insured 3								
Insured 4								
Insured 5								
Insured 6								

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.

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PREMIUM PAYMENT DETAILS*

Name of Premium payor: SURNAME MIDDLENAME FIRSTNAME

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:

Card details*: Master ☐ Visa ☐ Card No*.: Card Expiry Date*: D D M M Y Y Y Y

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

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.

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* (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.

Residential Status: ☐ Resident Individual ☐ Non-Resident Indian ☐ Foreign National ☐ Person of Indian Origin

If Non-Indian please specify the nationality and country address_____

If NRI please give details for resident country and address_____

☐ 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:

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.

Date: _____ Signature of Agent: _____

Place: _____ Licence No. _____

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DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

I. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.

ii. I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved under writing policy of the Insurance company and that the policy will come into force only after full receipt to the premium chargeable.

iii. I/We further declare that I/We 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.

iv. I/We declare and further consent to the company. Seeking medical information from any hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and /or claim settlement.

v. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/ or claims settlement and with any Governmental and/or Regulatory Authority.

vi. I/We are aware of premium loading, (if any declared above) for habits & diseases as declared / mention by me/ us above.

vii. 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.

viii. 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

ix. 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 the 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.

Date: D D M M Y Y Y Y

Place: _____

Signature of the Witness

Signature/Thumb impression of the Proposer/Primary Insured

SECTION 41 OF INSURANCE ACT, 1938

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

(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.

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