ENROLMENT FORM

HOSPICASH FLEXI INSURANCE

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

FOR OFFICE USE ONLY

Master Policy No.:
Quote No.: Inward No.:
Receipt No.: Receipt Date: D D M M Y Y Y Y

INTERMEDIARY DETAILS* (Mandatory field if Sales channel type selected is Banca)

Sales Channel Code: Specified Person's Code*/PF ID:
Business Sector: Urban Rural Social Others Segment Type: Corporate Retail SME _____
Business Type: New Renewal Migration Portability Sales Channel Type: Agency Direct _____
Sales Channel Code: Specified Person's Code*/PF ID:
Specified Person's Name* Or Staff Name:
Contact Details: Intermediary code:
Agreement code: GSTIN/ISDN: IF APPLICABLE

DETAILS OF POLICY*

Name: Unique enrolment ID/ Member ID:
Policy tenure: _____ (in months) Loan tenure: _____ (in months) Type of Loan _____
Period of Insurance: From D D M M Y Y Y Y To D D M M Y Y Y Y
Policy Type: Individual Family Individual Family floater

DETAILS OF PROPOSER/PRIMARY INSURED

Name of the Proposer/ Primary Insured* SURNAME MIDDLENAME FIRSTNAME
Present Address*: (Current Residing Address)
City: Village:
Gram Panchayat: State:
PIN code: Landmark:

My Present Address is same as Permanent Address

Permanent Address*:
City: Village:
Gram Panchayat: State:
PIN code: Landmark:

Nationality*: Indian Non-Indian Non-Residential Indian Email ID*:
Date of Birth*: D D M M Y Y Y Y Gender*: Male Female Others
Marital Status*: Married Unmarried Divorced Widow(er)
PAN No*.: Form 60/61*: As available
Contact Details*: Mobile No. Alternate Contact No.

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.

*Fields marked with Asterisk (*) are mandatory.

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 (DD/MM/YYYY)*						
Gender*						
Marital Status*						
Height (in cms)*:						
Weight (in Kgs)*:						
Nationality* (Indian/Non -Indian/ Non- Resident Indian / Others). In case of Nationality other than Indian, please provide details						
Occupation and Nature of Business/ Work*						
Relationship with Proposer*						
Basic Sum Insured (Separate only for Individual cover)*						
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)

COVERAGE DETAILS*

Coverage Name	Inbuilt/ Optional	Against opted cover	If Increased Deductible/ Franchise opted
Accident and sickness Hospital Cash Benefit:	Inbuilt	Compulsory Cover	Franchise ☐ Deductible ☐
Option to Choose Sum Insured/Benefit Amount:	500 day ☐ 750 day ☐ 1000 day ☐ 1500 day ☐ 2000 day ☐ 2500 day ☐ 3000 day ☐ 3500 day ☐ 4000 day ☐ 4500 day ☐ 5000 day ☐		
Option to Choose no. of Days:	10 days ☐ 15 days ☐ 20 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 100 days ☐		
Accident Hospital Cash Benefit:	Optional	Yes ☐ No ☐	Franchise ☐ Deductible ☐
ICU Cash Benefit:	Optional	Yes ☐ No ☐	Franchise ☐ Deductible ☐
Convalescence Benefit:	Optional	Yes ☐ No ☐	
Compassionate Benefit:	Optional	Yes ☐ No ☐	
Day Care Treatment Benefit:	Optional	Yes ☐ No ☐	
Maternity Hospital Cash Benefit: Option to reduce Maternity- waiting period 2 years/1 year/9 months/ No maternity waiting period	Optional	Yes ☐ No ☐ If yes- please tick opted waiting period:	Franchise ☐ Deductible ☐
Option to Choose Sum Insured/Benefit Amount for Maternity Cash Benefit:	500 day ☐ 750 day ☐ 1000 day ☐ 1500 day ☐ 2000 day ☐ 2500 day ☐ 3000 day ☐ 3500 day ☐ 4000 day ☐ 4500 day ☐ 5000 day ☐		
Option to Choose no. of Days:	5 days ☐ 10 days ☐		

Other Waiting Period (PED) Option 1. 30 days waiver Option 2: 2 years Specific illness waiting period Option 3: Specific illness Waiting Period Waiver Option 4: 1 year waiting period for Pre-Existing Diseases Option 5: 2 years waiting period for Pre-Existing Diseases Option 7: No waiting period for Pre-Existing Diseases	Optional	Yes ☐ No ☐ If yes- Please mention opted waiting period: _____
Increased Deductible/ Franchise	Optional	Yes ☐ No ☐ If Yes-Please mention Deductible or Franchise opted: _____

NOMINEE DETAILS*

Insured Name	**Insured 1**			**Insured 2**			**Insured 3**		
Nominee details	**Nominee 1**	**Nominee 2**	**Nominee 3**	**Nominee 1**	**Nominee 2**	**Nominee 3**	**Nominee 1**	**Nominee 2**	**Nominee 3**
Name of the Nominee*^									
% Share of Claim Amount									
Date of Birth (DD/MM/YYYY)*									
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									

Insured Name	Insured 4			Insured 5			Insured 6		
Nominee details	**Nominee 1**	**Nominee 2**	**Nominee 3**	**Nominee 1**	**Nominee 2**	**Nominee 3**	**Nominee 1**	**Nominee 2**	**Nominee 3**
Name of the Nominee*^									
% Share of Claim Amount									
Date of Birth (DD/MM/YYYY)*									
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									

^ (Please attach a separate sheet if required in case of multiple nominees)

*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 (DD/MM/YYYY)*						
Gender (M/F/O)						
Relationship with Nominee*						
Address of the Appointee						

Appointee Mobile no*						
Name of A/C 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).

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								

PREMIUM PAYMENT AND BANK ACCOUNT DETAILS*

Premium Amount ₹*: Cheque/Journal No*.: Date: D D M M Y Y Y Y

Premium payment option*: Cheque ☐ EFT ☐ DD ☐ Debit Card / Credit Card ☐

Bank Name*: IFSC Code:

Bank Account Number*:

Branch Name*: Card details*: Master ☐ Visa ☐

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

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.

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.

ELECTRONIC INSURANCE ACCOUNT DETAILS*:

I have an eIA Number

(a) NSDL Database Management Ltd ☐ (b) Centrico Insurance Repository Limited (Formerly Known as CDSL Insurance Repository Limited) ☐

(c) Karvy Insurance Repository Ltd. ☐ (d) CAMS Insurance Repository Services Ltd ☐

My 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)

DECLARATION FOR ASSIGNMENT OF POLICY:

You have an option to assign the Policy to the Financial Institution, on certain conditions to invoke the benefits under the Policy in case of non repayment of the loan at the unfortunate event of your death. Under such assignment you shall be responsible to pay all the premiums towards the Policy.

- I understand and wish to assign the Policy, as indicated above, which may be issued, to _____ the Financial institution (hereinafter referred to as the assignee) from whom I have availed loan.
- I further affirm that such assignment shall be subject to the condition that in the event of death during the term of the Policy, the benefit as per Policy terms and conditions will be paid to the said assignee to the extent of the outstanding loan amount only, if any. Any amount in excess after the above payment shall be paid to my nominee.
- I understand that after the end of the outstanding loan tenure as on the date of receipt of the proposal, the policy would be re-assigned to me. In the event of death after the end of the outstanding loan tenure, the benefit as per policy terms and conditions would be paid directly to my nominee.
- I understand that submission of this request shall be treated as adequate notice of assignment to the Company. The Company shall, after issuance of the Policy, endorse the same and recognize the Policy being assigned to the aforementioned assignee thereafter.

Date: D D M M Y Y Y Y

Place:

Signature of the Main Borrrower:

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.

Date: D D M M Y Y Y Y

Place:

Signature of the Witness Insured

Signature/Thumb impression of the Proposer/Primary.

DECLARATIONS ON BEHALF OF ALL PERSONS TO BE INSURED:

i) 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.

ii) 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.

iii) 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.

iv) 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.

v) 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."

vi) I/we aware of premium loading, (if any declared above) for diseases as declared / mentioned by me or us above.

vii) I/ We hereby agree to keep record of KYC details of all individual members covered under the Group Insurance including but not limited to HNI, Jewellers, NGO, Film Actor/Producer and PEPs to provide the details of benefciaries to the company as and when required.

Note: 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.

viii) I declare that the details provided in the proposal form will be used for both new and renewal purposes.

ix) I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the KYC of beneficial owner to the Company as and when required.

Date: D D M M Y Y Y Y

Place:

Signature

DECLARATIONS ON BEHALF OF ALL PERSONS TO BE INSURED:

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.

DISCLAIMER:

The details of all the individual members covered under the group insurance needs to be maintained by Master Policyholders. The concerned business function needs to ensure that the details of beneficiaries are made available to the Company as and when required.

Insurance is subject matter of solicitation.