



Permanent Address\*

City:  State:

Gram Panchayat:  Village:

PIN code:  Landmark:

Nationality\*:  Email ID\*:

Date of Birth\*:  Gender\*: Male  Female  Other

Marital Status\*: Married  Unmarried  Divorced  Widow(er)

AADHAAR No.\*:  PAN\*:  /Form 60/61 (if PAN not Available)\*:

Passport/ Driving License/ Others:  GSTN No.:

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

### Details of Plan:

Select the Plan: Base  Medium  Top

Sr No	Coverage Name	Inbuilt/ Optional	✓ Against opted cover	✓ against Franchise or Deductible opted							
1.	Accident and Sickness Hospital Cash Benefit	Inbuilt	Compulsory Cover	Franchise <input type="checkbox"/> Deductible <input type="checkbox"/>							
<b>Option to Choose Sum Insured/Benefit Amount:</b>											
500/day	<input type="checkbox"/>	750/day	<input type="checkbox"/>	1000/day	<input type="checkbox"/>	1500/day	<input type="checkbox"/>	2000/day	<input type="checkbox"/>	2500/day	<input type="checkbox"/>
3000/day	<input type="checkbox"/>	3500/day	<input type="checkbox"/>	4000/day	<input type="checkbox"/>	4500/day	<input type="checkbox"/>	5000/day	<input type="checkbox"/>		
<b>Option to Choose no. of Days :-</b>											
10/day	<input type="checkbox"/>	15/day	<input type="checkbox"/>	20/day	<input type="checkbox"/>	30/day	<input type="checkbox"/>	45/day	<input type="checkbox"/>	60/day	<input type="checkbox"/>
90/day	<input type="checkbox"/>	100/day	<input type="checkbox"/>								
2.	Accident Hospital Cash Benefit	Optional	Yes <input type="checkbox"/> No <input type="checkbox"/>	Franchise <input type="checkbox"/> Deductible <input type="checkbox"/>							
3.	ICU Cash Benefit	Optional	Yes <input type="checkbox"/> No <input type="checkbox"/>	Franchise <input type="checkbox"/> Deductible <input type="checkbox"/>							
4.	Convalescence Benefit	Optional	Yes <input type="checkbox"/> No <input type="checkbox"/>								
5.	Compassionate Benefit	Optional	Yes <input type="checkbox"/> No <input type="checkbox"/>								
6.	Day Care Treatment Benefit	Optional	Yes <input type="checkbox"/> No <input type="checkbox"/>								
7.	Maternity Hospital Cash Benefit	Optional	Yes <input type="checkbox"/> No <input type="checkbox"/>	Franchise <input type="checkbox"/> Deductible <input type="checkbox"/>							
	Option to reduce Maternity- waiting period:		If Yes - Please mention opted waiting period								
	i. 24 months										
	ii. 12 months										
	iii. 9 months										
	iv. No maternity waiting										
<b>Option to Choose Sum Insured/Benefit Amount for Maternity Cash Benefit:</b>											
500/day	<input type="checkbox"/>	750/day	<input type="checkbox"/>	1000/day	<input type="checkbox"/>	1250/day	<input type="checkbox"/>	1500/day	<input type="checkbox"/>		
1750/day	<input type="checkbox"/>	2000/day	<input type="checkbox"/>	2250/day	<input type="checkbox"/>	2500/day	<input type="checkbox"/>	2750/day	<input type="checkbox"/>		

3000/day	3250/day	3500/day	3750/day	4000/day
4250/day	4500/day	4750/day	5000/day	
<b>Option to Choose no. of Days:</b> 5 days <input type="checkbox"/> 10 days <input type="checkbox"/>				
8.	Shorter 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: year waiting period for Pre-Existing Diseases Option 5: 2 years waiting period for Pre-Existing Diseases Option 6: 3 years waiting period for Pre-Existing Diseases Option 7: No waiting period for Pre-Existing Diseases	Optional	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes - Please mention opted waiting period.
9.	Increased Deductible/ Franchise	Optional	Yes No <input type="checkbox"/>	If Yes- Please mention Deductible or Franchise opted.

**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 & Nature of Business/Work						
Nationality* (Indian/Non-Indian/ Non-resident Indian/Other)						
Relationship with Proposer*						
ABHA (Ayushman Bharat Health Account) number (if available)						

Note: By Family we mean Self, Spouse, Dependent children, Dependent parents and Dependent Parents in law max. up to 6 members.

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. | HospiCash Loan Insurance, UIN: SBIHLGP23005V012223 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

### Nominee Details:

Insured Name	Insured 1			Insured 2			Insured 3		
	Nominee 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3
Nominee details									
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 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3	Nominee 1	Nominee 2	Nominee 3
Nominee details									
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									

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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.

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of Appointee*						
Date Of Birth (DD/MM/YYYY)*						
Age*						
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								

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### 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
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Place:



Signature of Proposer

### 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 authorised 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 are aware of premium loading. (if any declared above) for habits & diseases as declared/mentioned by me/us above.
7. I/ We hereby agree to keep record of KYC details of all individual members covered under the Group Insurance and ensure to provide the details of beneficiaries to the Company as and when required.
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
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 Place:



Signature

### 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 liable for a penalty which may extend to Ten Lakhs rupees