ENROLMENT FORM

HOSPITAL DAILY CASH – GROUP – MICRO INSURANCE PRODUCT

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

POLICY DETAILS*

Policy Start Date: D D M M Y Y Y Y Policy End Date: D D M M Y Y Y Y
Policy Type*: Individual Family Individual Family floater
Sum Insured (in ₹)

DETAILS OF PROPOSER

Name of the Proposer* 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) Form 60/61*: As available
Aadhaar Card No*.: PAN No*.:
Contact Details*: Mobile No. Alternate Contact No.
Passport/ Driving License/ Others: GSTN 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.

COVERAGE DETAILS*

Coverage Name	Inbuilt/ Optional	Against opted cover	Against Franchise or Deductible 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 ☐		
Shorter Waiting Period (PED) Option 1: 30 days waiver Option 2: 24 Months Specific illness waiting period waiver Option 3: 12 Months Specific illness waiting period Option 4: 12 Months waiting period for PED Option 5: 24 Months waiting period for PED Option 6: 36 Months waiting period for PED Option 7: No waiting period for PED	Optional	Yes ☐ No ☐ If yes- Please mention opted waiting period: _____	
Increased Deductible/ Franchise	Optional	Yes ☐ No ☐ If Yes-Please mention Deductible or Franchise opted: _____	

INSURED PERSON DETAILS*

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name						
Date of Birth						
Age						
Gender						
Marital Status*						
Contact No.						

Relationship with Proposer*						
Nationality (Indian/ Non-Indian/ Non-resident Indian/ Other)						
Occupation & Nature of Business/Work						
Monthly Income in ₹						
Pre-existing Disease/s* Disability Details (if any)	Yes/No, If yes provide details	Yes/No, If yes provide details	Yes/No, If yes provide details	Yes/No, If yes provide details	Yes/No, If yes provide details	Yes/No, If yes provide details
ABHA (Ayushman Bharat Health Account) number (if available)						

If occupation is mentioned as Other, then please specify the occupation details.

Kindly confirm if insured engaged in activities of hazardous nature. (For example - mines, explosives, electrical installations on high tension lines, circus people, skiing, mountaineering, big game hunting, ballooning, hand gliding, river rafting, winter sports, ice hockey, polo).

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).

PREVIOUS/ EXISTING MEDICAL DETAILS OF MEMBER

Insured Name	Have you suffered in past or currently suffering from any disease/ disability/ medical (Physical / Mental) condition? If Yes please provide complete details	Type of Disability	Percentage of Disability
Insured 1	Yes ☐ No ☐		
Insured 2	Yes ☐ No ☐		
Insured 3	Yes ☐ No ☐		
Insured 4	Yes ☐ No ☐		
Insured 5	Yes ☐ No ☐		
Insured 6	Yes ☐ No ☐		

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.

DECLARATIONS ON BEHALF OF ALL PERSONS 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 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 and email.
7. I further declare that the contents of the Policy have been fully explained to me and I shall abide with the Policy terms and conditions.
8. I declare that the premium amount, corresponding to this proposal, is paid out of the legally declared and assessed sources of my income and not out of proceeds of crime related to any offence under the Prevention of Money Laundering Act, 2002 and rules framed thereunder.
9. 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

Date: D D M M Y Y Y Y

Place:

Signature

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)

VERNACULAR DECLARATION (IF SIGNED IN VERNACULAR LANGUAGE / IF YOU HAVE ANNEXED THUMB IMPRESSION ABOVE)

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 of the Proposer

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 Lakh rupees.

Insurance is subject matter of solicitation.