PROPOSAL FORM

HOSPITAL DAILY CASH INSURANCE POLICY

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Guidelines for completion of the form: 1) Please answer all the questions fully and accurately. Where any question does not apply, please mention clearly that the same is not applicable. 2) Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. If you think any fact is material, please disclose it. 3) The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or anyone acting on Proposer's behalf. Kindly contact SBI General Offices or Agents for any doubts or clarifications on the proposal form.

Important Information: Health Check Up/ Medical Examination will be required for acceptance of the proposal based on the Medical history, Sum Insured & age of the Proposer as per our guidelines. For all persons aged 60 and above, medical examination is compulsory, irrespective of the Sum Insured opted and pre-acceptance medical tests at the cost of the Proposer. However, if the Proposal is accepted the Insurer will reimburse 50% of the cost incurred towards the medical tests so undertaken at the advice of the Insurer.

OFFICE USE ONLY:

Branch office Code: Branch Name:

Business Type*: ☐ New ☐ Renewal ☐ Migration ☐ Portability Sales Channel Type: ☐ Digital ☐ Online

Business Sector*: ☐ Urban ☐ Rural ☐ Social ☐ Others

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

Intermediary Name:

Intermediary Code:

Intermediary Contact Details:

Intermediary Email ID:

PROPOSER DETAILS (*Mandatory Fields)

1. Do you have existing relationship with SBI General Insurance*? ☐ Yes ☐ No If Yes, then please mention the Customer ID:

2. Name*: SURNAME 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:

4. Nationality*: 5. Email: ☐ Paper Mail ☐ Phone

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

7. Email Address*: 8. Preferred Payment Mode: ☐ EFT ☐ Cheque

9. Gender*: ☐ Male ☐ Female ☐ Other 10. Marital Status: ☐ Married ☐ Single 11. Date of Birth*: D D M M Y Y Y Y

12. Aadhaar Card No.: 13. PAN*: /Form 97/98* (If PAN not available): ☐

14. Passport/Driving License/Voter ID:

15. What industry do you work in?*

16. Occupation*: ☐ Salaried ☐ Self Employed/ Professional ☐ Business ☐ Student ☐ Retired ☐ Agriculture & allied ☐ Others (specify_____)

Version: 1.0 Aug 2026

ACKNOWLDEGEMENT SLIP (Tear Off):

This is to certify that the amount of ₹ _____ will be debited from the Bank Account No. _____ of

Mr./Ms./Mrs._____ towards premium for SBI General's Hospital Daily Cash Insurance Policy

Signed at:_____ Journal No.:_____ Authorised Signatory for SBI General

Signature: _____ Journal Date: D D M M Y Y Y Y _____

Version: 1.0 Aug 2026

Disclaimer: SBI General Insurance Company Limited I 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. I 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 licence. | Hospital Daily Cash Insurance Policy, UIN: SBIHLIP11003V011011 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

18. Are you one among the Insured Persons Covered below? Yes ☐ No ☐

19. Are you or any of the proposed applicant* _____, please tick whichever is applicable: Yes ☐ No ☐

HNI ☐ Jeweller ☐ NGO ☐ Film Actor/ Producer ☐ PEP ☐

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.

If yes, please provide details for all person(s) in a separate sheet.

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.

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*						
Nominee*						
Appointee*						
ABHA (Ayushman Bharat Health Account) number (if available):						
Benefit Amount/ Sum Insured ₹:	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day	☐ 500/day ☐ 1000/day ☐ 1500/day ☐ 2000/day
Sum Insured Option:	☐ Individual ☐ Individual with family					
Sum Insured Plan:	☐ 30 Days ☐ 60 Days					

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		
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)*									

ACKNOWLDEGEMENT SLIP (Tear Off):

Note: (1) You shall receive the Policy copy on acceptance of your Proposal Form to the Head Office of SBI General Insurance Company. (2) Irrespective of the number of accounts the Insured has with SBI, he/she is allowed to take only one Policy. Multiple Policies for the same Insured are disallowed. (3) Even if multiple Policies are taken through one or more than one account with SBI for any reason, our liability will be restricted to only one Policy with the highest Sum Insured. All other Policies shall be deemed as null and void. Premium paid for all such Policies by Insured will be refunded after deduction of administrative expenses of ₹150. (4) In case of a Joint Account, two separate Policies may be issued in case both the account holders opt for respective Individual Policies. (5) Period of Insurance shall be 1 year from the date of transaction. (6) This acknowledgement slip does not in any way communicate the acceptance or commencement of risk under the application submitted by you. This is only an acknowledgement slip and is not the premium receipt. This acknowledgement slip should not be used for Income Tax purpose. The premium receipt shall be issued once the Company accepts the risk on your health and the amount deposited is applied to your Policy as premium. (7) Premium will be refunded in case your proposal is rejected by us. (8) For any assistance/ clarification required, kindly get in touch with SBI General Insurance Company Ltd. on 1800 22 1111, 1800 102 1111 (Toll Free).

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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)						

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Relationship with Nominee*						
Address of 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 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	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 (%):						

PERSONAL HEALTH DETAILS (To be filled in respect of all the members proposed to be covered under the policy)

Sr. No.	Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Are you in good health and free from physical and mental diseases or infirmity or medical complaints or deformity?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2	Lifestyle details of the Insured:						
2a	Is your occupation associated with any specific hazard? (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals etc.)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2b	Do you consume tobacco in any form? If Yes, whether it is: Cigarette/Beedi/Cigar/Gutka/Pan Masala/Others.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	Quantity per day:						
	Consuming for past:	_____years	_____years	_____years	_____years	_____years	_____years
	If you have stopped smoking or using tobacco products then please mention from when?						
2b	Do you consume alcohol? If Yes, type of alcohol: Beer/ Hard liquor/Wine/Others:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	Amount consumed per week:						
	Consuming for past:	_____years	_____years	_____years	_____years	_____years	_____years
	If you have stopped drinking then please mention from when?						
3	Have you ever suffered or taken treatment or have been recommended to take medication for the following by a medical practitioner?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3a	High Blood Pressure/Heart Attack/Cardiovascular disease, Diabetes, Tuberculosis, Asthma, or other Respiratory Disease, Kidney disorder, Bladder disorder, Urine abnormality, Renal stones or Genital organ disorder, Cancer or any form of Tumour or Lump, Cyst growth, Liver and Gall bladder disorder, Stomach or Duodenal disorder, Fistula, Piles, Hernia, Eye, Ear, Nose, Throat or Endocrine diseases, Diseases of bones, joints or spine, Stroke, Eplilepsy or any other disorder of Brain, Spinal cord or Nerves.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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3b	Any other illness/injury requiring investigation or treatment	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If answer to 3a or 3b is 'Yes', provide details of the ailment and nature of treatment in the Annexure.						
4	Have you ever been tested positive for HIV/AIDS, Hepatitis B or C or sexually transmitted diseases?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 DETAIL'S:

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 Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

Bank Account Number*: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Branch Name*: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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

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): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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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).

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_____

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

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:

VERNACULAR DECLARATION (If signed in vernacular language / If you have affixed 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/Thumb impression of the Proposer

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DECLARATION BY PROPOSER

1. I/We hereby declare on my/our behalf and on behalf of all the persons proposed to be Insured, that the above statements, answers and/ or particulars given by me/us are true and complete in all respects to the best of my/our knowledge and that I/We am/are authorised to propose on behalf of these other persons.
2. I/We understand that the information provided by me/us will form the basis of the Insurance Policy, is subject to the Board approved underwriting policy of the Insurance Company and that the Policy will come into force only after full receipt of the premium chargeable.
3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the person to be Insured / Proposer after the proposal has been submitted but before communication of the risk acceptance by the Company.
4. I/ We declare that I/ We consent to the Company seeking medical information from any doctor or from a hospital who at anytime 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 Insurance Company to which 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/We authorise the Company to share information pertaining to my proposal including the medical records for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/ or Regulatory Authority.
6. I/We aware of premium loading, (if any declared above) for habit's as declared/ mentioned by me /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.
8. 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
9. I declare that the details provided in the proposal form will be used for both new and renewal purposes.
10. 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 of Proposer:

SECTION 41 OF INSURANCE ACT, 1938

1. No person shall 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 of 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 in 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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HOSPITAL DAILY CASH INSURANCE POLICY

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Annexure to Hospital Daily Cash Insurance Policy

Sr. No.	Particulars	Details
1.	Name of the Insured:	
2.	Name & Address of the treating Doctor:	
3.	Nature of the Ailment (Exact Diagnosis):	
4.	Date of the First Diagnosis:	
5.	Nature of Symptoms (Onset, Duration and Intensity):	
6.	List of Prescribed Medication:	
7.	Further planned consultation (if any):	
8.	Details of Investigations performed along with the Dates and Results:	

Version: 1.0 Mar 2026

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