

VECTOR BORNE DISEASE COVER- GROUP

POLICYHOLDER DETAILS*

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

Name of the Proposer*:

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:

Contact Details*: Mobile No.: Alternate Contact

AADHAAR No. / Passport / Driving License/ Voter Id: Email*:

PAN*: /Form 60/61 (if PAN not Available)*:

Date of Birth*: Gender: M F Other

Occupation*: Salaried: Self Employed: Any Other (Please specify _____)

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.

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.

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 ₹						
ABHA (Ayushman Bharat Health Account) number (if available) #						

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
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
Name of the Nominee*^									

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% 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						

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IFSC Code						
MICR Code						
Bank Name						
Branch Name						

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).

MEMBER DETAILS

Name of the Group Policyholder:

Unique Enrolment No./ Member Id:

PRE-EXISTING DISEASE DECLARATION

- Are you currently suffering through Fever, chills, body aches, joint pain /swelling, nausea or vomiting? Yes No
If Yes, please specify details: _____
- Are you currently suffering from or have you suffered from Malaria / Dengue / Filariasis / Kala Azar / Chikungunya / Japanese Encephalitis / Zika in the past 3 months? Yes No
If Yes, please specify details and the no. of month _____

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.:

Premium Payment Option: Cheque EFT DD Debit Card/Credit Card Cheque Date:

Bank Name: IFSC Code:

Bank Account Number:

Branch Name: Card Details: Master Visa

Credit Card/ Debit Card No. Card Expiry Date:

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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:

Kindly visit our website www.sbigeneral.in to view the list of KYC OVD (Officially Valid Documents)

DECLARATION FOR UPDATE VIA DIGITAL MODE

"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 & email".

Date: Place: Signature of the Witness _____

AML GUIDELINES*

I/ We hereby confirm that all premiums have been/ will be paid from bonafide 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/We 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 statutes, directly or indirectly governing the prevention of money laundering in India.

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

Type of Organization:

Corporations Governments Non-Governmental Organizations
 Society Trust International Organization
 Partnership Cooperatives Section 8 Companies

Signature of Proposer:

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INSURER'S DECLARATION

Note: The liability of the company does not commence until the acceptance of the proposal has been formally intimated by the insured and full premium has been realized by the company.

We are under no obligation to accept any proposal for insurance. The Proposer agrees that the receipt of the Proposal Form by SBI General Insurance Company Limited along with the premium payment does not tantamount to the acceptance of the Proposal for insurance by SBI General Insurance Company Limited and does not result in a concluded contract of insurance. The acceptance of the Proposal for insurance shall be at the Company's sole and absolute discretion and upon full realization of the premium payment. In the event of acceptance of the Proposal for insurance by SBI General Insurance Company Limited, such acceptance shall be specifically intimated to the Proposer SBI General Insurance Company Limited along with the date from which the insurance Cover shall become effective. SBI General Insurance Company Limited shall not be liable for any claim in respect of an event giving rise to a claim covered under the Policy of Insurance that has occurred prior to policy issuance is not covered under this policy (Your proposal form will be considered after SBI General Insurance Company Limited receives premium payment.)

DECLARATION & WARRANTY 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 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 <http://www.healthid.ndhm.gov.in>

Date:

D	D	M	M	Y	Y	Y	Y
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 Place: Signature of the Witness _____

AGENT 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 nondisclosure 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.

Licence No.: _____

Date:

D	D	M	M	Y	Y	Y	Y
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 Place: Signature of the Witness _____

