PROPOSAL FORM

HEALTH EDGE INSURANCE

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Important Guidelines

1. Please answer all questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.
2. Kindly contact the Company's Offices or Intermediary for any doubts or clarifications on the proposal form.

Note: : The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by SBI General Insurance Company Limited. ("Company").

3. Information for fields marked with asterisk (*) are mandatory.
4. Only resident of India can be covered under this policy.

Office Use Only:

Branch office Code: Branch Name:

Business Type: ☐ New ☐ Roll-Over ☐ Renewal

Sales Channel Type: ☐ Digital ☐ Online

Intermediary Details:

Intermediary Name:

Intermediary Code:

Intermediary Contact:

Details:

Proposer Details:

Name of the Proposer*:

Communication Address*:

City: State:

Pin code: Landmark:

Nationality*: ☐ Indian ☐ Non-Indian _____(In case of Non-Indian, please provide nationality details)

Gender*: Male ☐ Female ☐ Others ☐

Date of Birth*: D D M M Y Y Y Y Marital Status*: Married ☐ Unmarried ☐ Divorced ☐ Widow(er) ☐

Email ID*:

Contact Details*: Mobile No: Alternate Mobile No:

As part of the Go Green initiative, we'll be issuing this policy in digital mode on your registered mobile number and e-mail ID. We save a tree when we issue an e-policy. A policy document sent electronically is as valid as a physical policy contract document. Date of delivery of the policy document is reckoned for the purpose of examining free look request. However, if you need a physical copy of the policy document, please send SMS "PRINT <Policy Number>" to 561612 from your registered mobile number.

PAN No.*: / Form 60/61 (If PAN not available): ☐

Aadhaar No.: Passport / Driving License/ Voter Id:

Annual Gross Income:

Profession*: Salaried ☐ Self-Employed ☐ Others ☐ details_____

Occupation and Nature of Business/ Work*: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Corporate: Yes ☐ No ☐ Total No. of Persons to be covered: ☐☐

GSTN/ISDN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Are you or any of the proposed applicant_____, please tick whichever is applicable: ☐ Yes ☐ No

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

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

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.

Are You Employee of SBI Group of Company? Yes ☐ No ☐

If Yes, then mention Name of Group and Employee Number_____

Policy Details:

Policy Type*: Individual ☐ Floater ☐ Policy Period*: 1 Year ☐ 2 Years ☐ 3 Years ☐

Policy Period: From D D M M Y Y Y Y To D D M M Y Y Y Y

SUM INSURED (IN Rs.) PLEASE TICK (✓)*

Plan Name	Sum Insured:
Health Edge Insurance	3 Lacs ☐ 5 Lacs ☐ 7 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐
No. of Days of Hospitalization covered	5 Days ☐ 10 Days ☐ Unlimited ☐
Optional Covers	Sum Insured / Sub Limit
Domestic help Indemnity (1A)	Rs. 50,000 ☐ Rs. 100,000 ☐
Hospital Daily Cash	Rs. 1000 / 10 days ☐ Rs. 2000 / 10 days ☐
Accidental Death Cover - Primary Insured	Rs. 10,00,000 ☐ Rs. 20,00,000 ☐
Healing Benefit (>5 days of Hospitalization)	Rs. 5,000 ☐ Rs. 10,000 ☐
Unlimited Refill (Related and Unrelated Illness both)	Unlimited Refill - Anyone Illness Waiver ☐
Vector Borne Fixed Benefit	Rs. 50,000 ☐ Rs. 100,000 ☐
Critical Illness Cover (60 Illness covered) (90 days Waiting Period)	Fixed Benefit up to Base Sum ☐
Claims Safeguard	Non-payable items covered ☐
OPD Cover	Rs .5000/ Member ☐
Booster Benefit (reduction is same proportion in case claim is settled)	50% of Base Sum Insured up to 200% of Base Sum Insured
E-Opinion	☐ Yes ☐ No
Women Care Benefit • Maternity Expenses (Normal Delivery - ₹25000 and C – Section ₹50000) • New Born Baby Cover (Covered up to Sum Insured)	☐ Yes ☐ No

Assisted Reproduction Treatment	Rs 1,00,000 ☐
Global Cover	Listed illness
Wellness Benefit	Health Assistance (A.I. Personal Fitness coaching), Dietician and Nutrition E-consultation, Walk Healthy Benefit ☐ Unlimited Gym Membership ☐
Co-payment	10% ☐ 20% ☐

Details Of The Person Proposed To Be Insured:

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name *						
Date of Birth*						
Age*						
Gender*						
Marital Status*						
Occupation*						
Nationality* (Indian/ Non-Indian/ Non-resident Indian/Other)						
Relationship with Proposer*						
Basic Sum Insured*						
ABHA (Ayushman Bharat Health Account) number (if available)						

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

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)

Optional Covers:

Additional Basic Sum Insured for Accident related hospitalization	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Health Assistance (A.I Personal Fitness Coaching), Dietician and Nutrition E – Consultation, and Unlimited Gym Membership	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Walk Healthy Benefit	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

^Please note: If the child above 18 years of Age is financially independent, he or she shall be ineligible for coverage under this Policy in the subsequent renewals.

In case, policy is proposed for more than 6 Insured persons, kindly fill the details in an annexure.\

Nominee Details:

In the event of death of the Insured Person any payment due under the policy shall become payable to the nominee in accordance with the policy terms and conditions. Nominee must be immediate relative (Mother, Father, Spouse, Son, and daughter) of the proposer.

Name	Contact Details	Date of Birth	Gender	Relationship with Proposer
		D D M M Y Y Y Y	M ☐ F ☐ Other ☐	

Where Nominee is a minor, give the details of Appointee

Name of the Appointee	Relationship with Nominee	Appointee Contact details

Previous / Existing Insurance:

Are you applying for portability / Migration: Yes ☐ No ☐

(If "Yes", please fill the separate portability form also)

Previous Insurance Details

Does any person to be insured holds any Health Insurance Policies?

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)						

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	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of Illness/ disease/Injury/ Disability:						
Duration since suffering from:						

Medications details (present/ past) please specify:						
Are you fully cured- Yes/No?						

Additional Medical History (If Any):

(Describe complete details of disease, Surgery if any, Disability %, date of diagnosis, details of treatment)_____

_____

_____

Domestic Help / Staff Indemnity Cover^

Domestic Help / Staff Indemnity Details	Domestic Help/ Staff 1	Domestic Help/ Staff 2	Domestic Help/ Staff 3	Domestic Help/ Staff 4
Name				
Gender (Male/Female/Others)				
Marital Status (Married/Unmarried/ Divorced/Widower)				
Date of Birth (DD/MM/YYYY)				
Nationality [Indian/Non-Indian (In case of Non-Indian, please provide nationality details)]				
Declaration of Good Health (I declare that I am of good health and I do not have any physical defect, deformity or disability. I further declare that I perform all my routine activities independently, that I do not have any history of, have never suffered from, am not currently suffering from, nor have I received, nor am I currently receiving, nor do I expect to receive any treatment, nor been hospitalized, nor do I expect to be hospitalized for any ailment or disease.) PLEASE TICK (✓)	☐	☐	☐	☐
Nature of Duty				
Occupation				
Sum Insured (50,000/1 Lakh) PLEASE TICK (✓)	☐ 50,000 ☐ 1 Lakh	☐ 50,000 ☐ 1 Lakh	☐ 50,000 ☐ 1 Lakh	☐ 50,000 ☐ 1 Lakh
Place				
Date				
Signature/Thumb impression of the Proposed Insured (Domestic help/staff)				

Proposer Declaration:

I _____(Full Name) of _____ (current residential address) hereby solemnly declare that I will be availing the services of the Domestic help(s)/staff(s) whose details are set out hereunder,

Date: D D M M Y Y Y Y

Place:

Signature of the Insured

Details Of The Family Doctor:

Name of the Doctor:

Mobile No.: Contact No.:

Registration No. of the Family Doctor:

Premium Payment And Bank Account Details:

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

Bank Name: Branch Name:

Name of the A/c. Holder: IFSC Code:

Bank Account No: MICR Code:

Premium Amount: (in words)_____

Premium Payment Option: Monthly ☐ Quarterly ☐ Half Yearly ☐ Annual ☐ Single Premium ☐

Premium payment mode option: Cheque ☐ DD ☐ Debit Card / Credit Card ☐ Card Details: Master ☐ Visa ☐

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

SBIGI does not accept Cash for Premium Payments against the Policy.

Bank Account Details For Process Of Refund:

Cheque will be issued in the name of the Proposer only.
In case of cancellation of Policy, if premium was paid through credit card, the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account: (Cancelled Cheque should be of the same bank account in which the refund / claim needs to be credited directly.)

Bank Name: Branch Name:

Name of A/c. Holder: IFSC Code:

Bank Account No: 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 Want Health Edge Insurance Policy

Physical Format- Yes ☐ No ☐ e-Format (electronic) as & when applicable- Yes ☐ No ☐

Choose your Insurance Repository (For those selecting e-Format)

(a) NSDL Data Management Ltd. ☐ (b) CDSL Insurance Repository Ltd. ☐

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

☐ I have an e-Insurance Account & the No. is :

My CKYC No. (Central Know Your Customer registry number) is (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 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: D D M M Y Y Y Y

Place:

Signature of the Insured

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

Place:

Signature of the Insured

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.

Nationality: Indian ☐ Non-Indian ☐ Non-resident Indian(NRI) ☐ Others ☐

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

Insurer 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 Proposal and 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 Policyissuance, notcovered under this Policy (Your proposal form will be considered after SBI General Insurance Company Limited receives the premium payment.)

Declarations On Behalf Of All Persons Proposed To Be Insured:

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.

Date: D D M M Y Y Y Y

Place:

Signature of the Insured

Proposer Declaration:

The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract.

Date: D D M M Y Y Y Y

Place:

Signature of the Proposer

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 non-disclosure 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.

License No.: _____

Date: D D M M Y Y Y Y

Place:

Signature of the Agent

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)_____(relationship 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 my/our knowledge and belief.

Signature of the Witness Insured

Signature/Thumb impression of the Proposer/Primary.

Date: D D M M Y Y Y Y

Place:

Sharing of Information: The information sought from the Insured is for the purpose of Policy issuance and Policy servicing. This information sought and the details of the Policy are kept confidential and will not be shared with any external party in any circumstances whatsoever. However, in instances when such information / details are sought by any governmental bodies, regulatory authorities reinsurer or when the Company is directed to share such information in accordance with any law/ regulations or directions from any such government bodies / regulatory authorities, the Company will be bound to abide to such directions.

Fraud Warning: This Policy shall be voidable at the option of the Company in the event of mis-representation, mis-description, or non-disclosure of any material particulars by the Proposer. Any person who, knowingly and with intent to fraud the Insurance Company or any other person, files a proposal for Insurance containing any false information, or conceals for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, It will render the Policy voidable at the sole discretion of the Insurance Company and result in a denial of Insurance benefits.

Section 41 Of Insurance Act, 1938:

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 of risk relating to lives or property in India, any rebate of the 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 rebates as may be allowed in accordance with the prospectus or tables of the Insurer.

Any person making default in complying with the provisionsof this section shall be punishable with fine which may extend to ₹10 lacs.

Insurance is subject matter of solicitation.

AML Declaration as per AML Master Guideline 2022:

1. Determination of Beneficial Ownership:

I/We hereby confirm that the below mentioned person/s have controlling ownership interest/ exercises control through other means and shall be considered for the purpose of determining Ultimate Beneficial Owner:

Sr. No	Name of Ultimate Beneficial Owner	Percentage (%)*	Remarks, if any

***Notes:**

a) Where the client is a company, the beneficial owner(s) is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has a controlling ownership interest or who exercises control through other means.

1. **"Controlling ownership interest"** means ownership of or entitlement to more than **ten percent of shares or capital or profits of the company;**
2. **"Control"** shall include the right to appoint majority of the directors or to control the management or policy decisions including by virtue of their shareholding or management rights or shareholders agreements or voting agreements;

b) Where the client is a partnership firm, the beneficial owner(s) is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of/entitlement to more than **Ten percent of capital or profits of the partnership.**

c) Where the client is an unincorporated association or body of individuals, the beneficial owner(s) is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of or entitlement to more than **fifteen percent of the property or capital or profits of such association or body of individuals.**

d) Where no natural person is identified under (a) or (b) or (c) above, the beneficial owner(s) is the relevant natural person who holds the position of senior managing official.

e) Where the client is a trust, the identification of beneficial owner(s) shall include identification of the author of the trust, the trustee, the beneficiaries with **ten percent or more interest in the trust** and any other natural person exercising ultimate effective control over the trust through a chain of control or ownership.

Date:

Signature of Policyholder: