# PROPOSAL FORM

## AROGYA PLUS 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 Proposer 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 Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material particular to the proposal form/ personal statement, declaration and connected documents or any material information having been with held by the Proposer or anyone acting the on Proposer's behalf. 4. Kindly contact SBI General Offices or Agents for any doubts or clarifications on the proposal form. Important Information: Health Check-Up/ Medical Examination may be required for all persons aged 55 years and above, and pre-acceptance medical tests is 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.

### FOR OFFICE USE

Quote No.: Inward No.:

Receipt No.: Receipt Date: D D M M Y Y Y Y

### INTERMEDIARY'S DETAILS (* Mandatory Fields if Sales Channel Type selected is Banca)

Segment Type: ☐ Corporate ☐ Retail ☐ SME Business Sector: ☐ Urban ☐ Metro ☐ Rural ☐ Village ☐ Social

Business Type: ☐ New ☐ Roll-Over ☐ Renewal Sales Channel Type: ☐ Banca ☐ Agency ☐ Direct

Sales Channel Code: Specified Person's / Intermediary's Code*:

Specified Person's / Intermediary's Name*:

GSTIN/ISDN: IF APPLICABLE

### PROPOSER'S DETAILS (* Mandatory Fields)

1. Name*: S U R N A M E M I D D L E N A M E F I R S T N A M E

Gender*: ☐ Male ☐ Female ☐ Others Date of Birth*: D D M M Y Y Y Y

Marital Status*: ☐ Single ☐ Married ☐ Others

Occupation*: ☐ Salaried ☐ Self Employed/ Professional ☐ Business ☐ Student ☐ Retired ☐ Agriculture ☐ Others (specify) _____)

2. Address where you normally reside (Communication Address)*:

Plot No./Door No.: Building name:

Road: Area:

City: Pincode:

State: Mobile No.*:

Email ID*: Alternate Mobile No.*:

3. Address of the Insured if different from above (Permanent Address)*:

Plot No./Door No.: Building name:

Road: Area:

City: Pincode:

State: Nationality*:

Mobile No.*: Alternate Mobile No.*:

Email ID*:

4. Policy Term*: ☐ 1 Year ☐ 2 Years ☐ 3 Years 5. Are you one among the Insureds Covered below?* ☐ Yes ☐ No

6. Policy Period*: From: D D M M Y Y Y Y To: D D M M Y Y Y Y 7. Total No. of Persons to be covered*:

8. Nominee's Name*:

9. Nominee's Relationship with the Proposer*: Date of Birth: D D M M Y Y Y Y

Nominee Contact Number:

10. If the Nominee is a minor, Name of the Appointee and his relationship with the Nominee*:

Appointee contact Number:

11. Aadhaar Card No.: 12. PAN No*.: / FORM 60/61* (If PAN not available):

13. Passport/Driving License/Voter ID: 14. GSTIN/ISDN*: IF APPLICABLE

15. Corporate*: Yes No

16. 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.

**DETAILS OF COVERAGE SOUGHT**

Note: By Family we mean You, Your legal Spouse, Legal & Dependent Children, Dependent Parents and Parents-in-law (Parents, Parents-in-law, cannot be covered under Family Floater).

| | | | |
|---|---|---|---|
| Policy Term (Please tick): | 1 Year | 2 Years | 3 Years |
| Type of Policy (Please tick): | Individual | Family Non-floater | Family Floater |
| Sum Insured: | ₹1 Lac | ₹2 Lacs | ₹3 Lacs |
| Premium before taxes as applicable: | ₹8,900 | ₹13,350 | ₹17,800 |

## ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want Arogya Plus Policy and related information in: Physical Format e-Format (electronic); as & when applicable.

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

NSDL Data Management Ltd. CDSL Insurance Repository Ltd. Karvy Insurance Repository Ltd. 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).

## MEMBERS PROPOSED FOR INSURANCE (* Mandatory Fields)

| Details | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 | Insured 6 |
|---|---|---|---|---|---|---|
| Name* | | | | | | |
| Gender* | | | | | | |
| Date of Birth* | | | | | | |
| Marital Status* | | | | | | |
| Relationship with the Proposer* | | | | | | |
| Occupation* | | | | | | |
| Nationality* (Indian/ Non-Indian /Non-resident Indian/Other) | | | | | | |
| Other Insurance* Yes No | | | | | | |
| 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)

## 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 (%): | | | | | | |

## DETAILS OF ILLNESS/ACCIDENT

Do any of Insured suffer from physical /mental disease or infirmity or medical complaints or deformity? If yes, name the Insured and the Disease. ☐ Yes ☐ No

Do any of the Insured smoke? ☐ Yes ☐ No

Do any of the Insured consume any other type of tobacco including betel nut? ☐ Yes ☐ No

Do any of the Insured consume alcohol? ☐ Yes ☐ No

## PAYMENT DETAILS (Claim/Refund amount will be deposited in this Bank Account only unless changed subsequently)

Please draw your Cheque (A/c payee only) in the name of **"SBI General Insurance Company Limited"** (*Mandatory fields)

Instrument Type: ☐ Cheque/ ☐ Debit Card/ ☐ Credit Card

Cheque No./DD No.: ☐☐☐☐☐☐ Amount: ☐☐☐☐☐☐☐☐☐☐ Date: D D M M Y Y Y Y

Bank Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Branch: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Account No.*: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ IFSC Code*: ☐☐☐☐☐☐☐☐☐☐☐

Period of Insurance: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

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

## 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 :

## 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 up to ₹ 10 Lacs.

## AGENTS 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.

Licence No. _____

Date: D D M M Y Y Y Y Place: _____ Signature of Agent: _____

## 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.

Date: D D M M Y Y Y Y Place: _____ Signature of Proposer: _____

Name of the Proposer: _____

## 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

## 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:

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SBI general INSURANCE

SURAKSHA AUR BHAROSA DONO