

INDIVIDUAL PERSONAL ACCIDENT INSURANCE POLICY

Guidelines for completion of the form: Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable. Kindly contact SBI General Office for any doubts or clarifications in the Proposal Form.

The liability of SBI General does not commence until this proposal has been accepted by SBI General and premium paid and upon full realisation of the premium payment by the Company, the acceptance of which shall be specifically intimated to the Proposer by the Company along with the date from which the Insurance Cover shall become effective and the Insurance Cover shall only be effective from the date as intimated by the Company.

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

Segment Type: Corporate Retail SME Business Sector: Urban Rural Social

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

Sales Channel Code: Specified Person's Code*:

Specified Person's Name*:

GSTIN/ISDN: IF APPLICABLE

PROPOSER'S DETAILS

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

2. Name of the Insured Person: F I R S T N A M E M I D D L E N A M E S U R N A M E

3. Relationship between the Proposer and the Insured Person:

4. Residential / Permanent Address of the Insured: Pincode:

5. Contact Details: Tel. No.: Mobile No.:

6. Email Address: 7. Aadhaar ID No.:

8. ABHA (Ayushman Bharat Health Account) number (if available):

9. Period of Insurance: From: D D M M Y Y Y Y To: D D M M Y Y Y Y PAN No.:

10. Profession/Occupation/Trade or Business (Please describe fully with nature of duties):

11. Do you engage in racing on wheels or horseback, big game hunting, mountaineering, winter sports, skating or ice hockey, ballooning or polo or sports of similar nature? Yes No

12. Where does your average monthly come from:
 Gainful Employment: Other Sources: Total in ₹:
 Gross Annual Income in ₹:

13. Date of Birth: D D M M Y Y Y Y Martial Status: Gender: Male Female Other

14. Are you an employee of SBI Group Company? Yes No
 If 'Yes', please state the name of the company and employee code:

15. Have you suffered or do you suffer from:
 Any physical defect or infirmity Gout or Arthritis or Diabetes or Paralysis Fits of any kind or any other chronic disease Any other disability
 Full particulars must be given in case the answer is 'Yes' to any of the following queries:

16. Is this proposal for insurance in addition to:
 - Any other Accident Policy? (including if covered under any Group Personal Accident Policy/Credit Card Schemes) Yes No
 If so, give the name of each Company, Policy Number and Amount of Insurance: _____
 - Any other Employee Scheme? Yes No
 If so, give the name of each Company and Amount of Insurance: _____

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.

Disclaimer: SBI General Insurance Company Limited | Corporate & Registered Office: Fulcrum Building, 9 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. | 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 license. | Individual Personal Accident Insurance Policy, UIN: SBIPAIP12002V011112 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products

17. Has any Company:

- Declined to issue a Policy to you? Yes No
- Declined to continue your Insurance? Yes No
- Imposed any restriction or special conditions? Yes No

If Yes, please furnish the details: _____

18. Do you wish to cover your family members (spouse, children and dependent parents only)? Yes No

If Yes, please furnish the information in the table given below:

Name of the Family Member	Relationship with the Insured and Age	Profession or Occupation	Annual Income

Please select the coverage:

Every member of the family has the option to choose any benefit from table A, B, C,D and the fixed Sum Insured. However the table of benefit opted by family members should not be more than the benefit chosen by the Primary Insured. Maximum Sum Insured is ₹ 1,00,00,000/- and the minimum Sum Insured is ₹ 1,00,000/- . Sum Insured for Accidental Death Benefit/Permanent Total Disability is limited to 120 times the monthly gross income or 10 times the annual gross earnings from gainful employment/ occupation. Sum Insured to dependent children, dependent parents, parents-in-law and unemployed spouse is limited to 20 % of Sum Insured of the Primary Insured or ₹ 10,00,000/- (whichever is less).

Benefit	Sum Insured Opted (Add sheet if columns are less)					
	Primary Insured	Spouse	Dependent Child 1	Dependent Child 2	Dependent Parents	Dependent Parents-in-law
Table A - Accidental Death						
Table B - Accidental Death and Permanent Total Disablement (PTD)						
Table C - Accidental Death, (PTD) and Permanent Partial Disablement(PPD)						
Table D - Accidental Death, (PTD), (PPD) and Temporary Total Disablement						

-Permanent Total Disability (PTD) benefit comes with the following benefits at no additional cost .

-Education Benefit - Death & Permanent Total Disability claims entitle the Insured's child and spouse to Education Benefit to maximum two individuals (children/ spouse) on proof of enrolment at a Government approved education facility at ₹ 50,000/- or 1% of CSI (basic SI), whichever is lower for each child/spouse.

-Adaption Allowance - Permanent Total Disability claims also include payment towards cost of modifying the Insured's house or vehicle to combat disability @1 % or ₹ 25,000/- whichever is less.

Additional Covers (Please provide Sum Insured for the covers opted):

Benefit	Yes (Specify the limit)	No
Hospital Confinement Allowance The per day allowance is ₹ 1000 / 2000 / 3000/- with a maximum coverage for 15 days for the entire policy period (If You are admitted in a Hospital due to Injury or Accident that occurs within the Republic of India.)	₹ 1000 / 2000 / 3000	
Ambulance including Air Ambulance Sum Insured @ 10% subject to a maximum of ₹ 1,00,000/- per Policy Period towards expenses incurred for availing an Ambulance Service [Expenses incurred for availing an Ambulance Service (including Air Ambulance) to transfer the Insured Person to a hospital from the location of Accident or Injury or from one hospital to another hospital or from hospital to the place of residence in case of death or PTD. The ambulance service will be for the transit within India only.] Ambulance cover available only when AD Sum insured is ₹ 5,00,000 and more.	Write Yes if opted	

19. Corporate: Yes No 20. GSTIN/ISDN: IF APPLICABLE

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

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).

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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)

Cheque No./DD No.: [] Amount: [] Date: [D] [D] [M] [M] [Y] [Y] [Y] [Y] Bank Name: [] Branch: [] Bank Account No.: [] IFSC Code: []

AML GUIDELINES

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 statutes, directly or indirectly governing the Prevention of Money Laundering in India.

Nationality: Indian Non-Indian Non-Indian, please specify Country: _____

Type of Organisation:

Corporation Government Non-Governmental Organisation Society Trust Partnership International Organisation Cooperative Section 25 Companies

Signature of Proposer: []

^Political expose parties (PEP'S) - Politically Exposed Parties are group of persons who are or have been entrusted with prominent public functions i.e., Heads / ministers of central or state government, senior politicians, senior government, judicial or military officials, senior executives of government companies, important party officials.

NOMINATION (Mandatory)

I _____ do hereby nominate Mr./Mrs./Ms. _____ as the person authorised to receive the amount payable by SBI General in the event of my Accidental Death and he/she is related to me as _____ (Relationship to the Insured) and I further declare that his/her receipt shall be sufficient for discharge to the Company.

In case of the nominee being minor: I _____ do hereby nominate Mr./Mrs./Ms. _____ as the Guardian of the nominee mentioned above. I authorise him/her to receive the amount payable by SBI General in the event of my accidental death and I further declare that his/her receipt shall be sufficient for discharge to the Company.

Dated this _____ Day of _____ 20 _____ at _____ Signature of the Witness: _____ Signature of the Proposer: _____ Name and Address of the Nominee: _____ Date of Birth of the Nominee: _____

DECLARATION

1. I/We hereby declare on my behalf and on behalf of all the 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/We am/are authorised to propose on behalf of these other persons. 2. I/We 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 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 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 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.

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.

Specified Person Name: _____ Specified Person Code: _____ Licence No. _____ Date: [D] [D] [M] [M] [Y] [Y] [Y] [Y] Place: _____ Signature of Agent: []

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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 PUNISHABLE WITH FINE, WHICH MAY EXTEND UP TO ₹ 10 LAKHS.

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 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 declare that whatever I/We have stated hereinabove is true and correct to the best of my knowledge and belief.

Date:

D	D	M	M	Y	Y	Y	Y
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Place:

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Signature of the Witness

Signature/Thumb impression of the Proposer

CUSTOMER'S/INDIVIDUAL'S/INSURED'S DETAILS SECTION

I would like to receive my Insurance Policy and all the information related to the proposed Insurance Policy through Insurance Repository in the Electronic Format as and when applicable.

Please select the name of the Insurance Repository:

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

CAMS Repository Services Ltd. _____

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:

***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: