

Guidelines For Completion Of The Form:

- Please answer all questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.
- 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").

Office Use Only:

Branch office Code: Branch Name:

Business Type: New Roll-Over Renewal
 *Incase of Renewal please share your Policy Number:

Sales Channel Type: Banca Agency Direct Broker POS CSC Corporate Agent

Intermediary Details:

Intermediary Name:

Intermediary Code:

Intermediary Contact:

Details:

SP Name : SP Code:

SP's Mobile Number : *RM ID :

Proposer Details:

Name of the Proposer:

Do you have an existing relationship with SBI General ? Yes No If Yes, please mention the Customer ID

Customer ID: SBI Employee ID :

Address:

City: State:

Pin code: Gender: M F Transgender

Date of Birth Marital Status: Married Unmarried Divorced Widow(er)

Phone: Mobile No.

Aadhaar No.: PAN: / Form 60

Profession: Salaried Self-Employed Others Pls add details _____

Email ID: Nationality:

Nature of Business: Annual Income:

GSTN/ISDN:

Disclaimer: SBI General Insurance Company Limited | 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. | 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. | URN: SBIG/ASR/V.01/31012021 | Arogya Supreme UIN: SBHILIP21043V012122

Are You or any of the proposed applicants a Politically Exposed Person? Yes No

Politically Exposed Persons (PEP) are individuals 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.

Are You an Employee of SBI Group of Companies? Yes No

If Yes, then mention the Name of Group and Employee Number _____

Does any person to be insured presently hold any other Retail Insurance Policy with SBI General Insurance?

Yes No If Yes, then provide the below details

Current Insurance Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
Policy Number							
Period of Insurance							

Policy Details:

Policy Type: Individual Floater

Policy Period: 1 Year 2 Years 3 Years

Policy Period: From To Plan: Pro Plus Premium

Sum Insured (In Rs.):

Plan Name	Sum Insured			
PRO	1 Lac <input type="checkbox"/>	2 Lac <input type="checkbox"/>	3 Lac <input type="checkbox"/>	4 Lac <input type="checkbox"/>
	5 Lac <input type="checkbox"/>			
PLUS	6 Lac <input type="checkbox"/>	7.5 Lac <input type="checkbox"/>	10 Lac <input type="checkbox"/>	12.5 Lac <input type="checkbox"/>
	15 Lac <input type="checkbox"/>	17.5 Lac <input type="checkbox"/>	20 Lac <input type="checkbox"/>	
PREMIUM	25 Lac <input type="checkbox"/>	30 Lac <input type="checkbox"/>	35 Lac <input type="checkbox"/>	40 Lac <input type="checkbox"/>
	45 Lac <input type="checkbox"/>	50 Lac <input type="checkbox"/>	75 Lac <input type="checkbox"/>	1 Crore <input type="checkbox"/>
	1.5 Crore <input type="checkbox"/>	2 Crore <input type="checkbox"/>	2.5 Crore <input type="checkbox"/>	3 Crore <input type="checkbox"/>
	3.5 Crore <input type="checkbox"/>	4 Crore <input type="checkbox"/>	4.5 Crore <input type="checkbox"/>	5 Crore <input type="checkbox"/>

Room Rent	Sum Insured ₹3 Lac and 4 Lac	Single /Private AC Room <input type="checkbox"/> 1% of Base Sum Insured <input type="checkbox"/>
ICU / ICCU	Sum Insured ₹3 Lac and 4 Lac	As per actual ICU/ICCU expenses provided by hospital. <input type="checkbox"/> 2% of Base Sum Insured <input type="checkbox"/>

Optional Covers:

Optional Covers	Yes / No	Sum Insured / Sub Limit
Hospital Cash Benefit		PRO / PLUS / PREMIUM
		500 <input type="checkbox"/> 1000 <input type="checkbox"/> 2500 <input type="checkbox"/> 5000 <input type="checkbox"/> 5 days <input type="checkbox"/> 10 days <input type="checkbox"/> 15 days <input type="checkbox"/> 45 days <input type="checkbox"/>
Major Illness Benefit		100% of Sum Insured maximum up to Rs. 25,00,000/-

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Additional Sum Insured for Accidental Hospitalization		1.5X <input type="checkbox"/> 2X <input type="checkbox"/> of the Basic Sum Insured
Enhanced Cumulative Bonus		PRO 25% up to a Maximum of 200%
		PLUS / PREMIUM 50% up to a Maximum of 200%
NCB Protector		If claim is less than Rs. 50,000/- We will protect NCB% at the time of Renewal of Policy with Us
Co-Payment		10% <input type="checkbox"/> 20% <input type="checkbox"/>
Any Room Upgrade (Upgrade to any room excluding a suite and above)		PRO (applicable to 5 Lac Sum Insured) <input type="checkbox"/>
		PLUS 6 Lac to 20 Lac <input type="checkbox"/>
		PREMIUM Not applicable <input type="checkbox"/>
Deductible		10,000 <input type="checkbox"/> 25,000 <input type="checkbox"/>

Details Of The Person Proposed To Be Insured:

Sr. No	Name	Date of Birth	Age	Gender	Marital Status	Occupation and Nature of Business/ Work	Relationship with Proposer	Basic Sum Insured
1		<input type="text"/>		M <input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/>				
2		<input type="text"/>		M <input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/>				
3		<input type="text"/>		M <input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/>				
4		<input type="text"/>		M <input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/>				
5		<input type="text"/>		M <input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/>				
6		<input type="text"/>		M <input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/>				

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.

Nominee Name	
Nominee Relationship	
Nominee Age	

Where Nominee is a minor, give the details of Appointee.

Name of the Appointee	Relationship with Nominee	Address of Appointee

Previous / Existing Insurance:

Are you applying for portability / Migration: Yes No

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

Does any person to be insured had held any Health Insurance / Critical Illness Insurance Policies?

Yes No If Yes, then provide below details

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Call (Toll Free) | 1800 22 1111 | 1800 102 1111 | www.sbigeneral.in

Previous Insurance Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
Policy Number							
Insurer's Name							
Period of Insurance							
Sum Insured							
Premium Paid (Rs)							
Claim Details (if any) Incurred Claim (Outstanding + Received): Claim Ratio (%):							

Does any person to be insured presently hold any Health Insurance / Critical Illness Insurance Policies?

Yes No If Yes, then provide below details

Current Insurance Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
Policy Number							
Insurer's Name							
Period of Insurance							
Sum Insured							
Premium Paid (Rs)							
Claim Details (if any) Incurred Claim (Outstanding + Received): Claim Ratio (%):							

Medical And Life Style Information:

If answer is Yes, then please specify and attach the relevant medical reports from Medical Practitioner if any, Has any of the persons proposed to be insured ever suffered from/ are currently suffering from any of the illnesses/ diseases or any pre-existing accidental injury?

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7

Do you consume any of the following substances?

1	Alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Smoking	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Pan Masala /Gutkha	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Any Other substance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Additional Medical History (If Any):

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

Details Of The Family Doctor:

Name of the Doctor:

Mobile No. Contact No.

Registration No. of the Family Doctor:

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Premium Payment And Bank Account Details:

Cheque/Journal No.:	<input type="text"/>	Cheque Date:	D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/>	Amount for ₹	<input type="text"/>
Bank Name:	<input type="text"/>	Branch Name:	<input type="text"/>		
Name of the A/c. Holder:	<input type="text"/>	IFSC Code:	<input type="text"/>		
Bank Account No.:	<input type="text"/>		MICR Code:	<input type="text"/>	
Premium Amount: (in words) _____					
Premium Payment Option:	Monthly <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Half Yearly <input type="checkbox"/>	Annual <input type="checkbox"/>	Single Premium <input type="checkbox"/>
Premium payment mode option:	Cheque <input type="checkbox"/>	DD <input type="checkbox"/>	Debit Card / Credit Card <input type="checkbox"/>	Card Details: Master <input type="checkbox"/>	Visa <input type="checkbox"/>
Card No.	<input type="text"/>	Card Expiry Date:	M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/>		

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:	<input type="text"/>	Branch Name:	<input type="text"/>
Name of A/c. Holder:	<input type="text"/>	IFSC Code:	<input type="text"/>
Bank Account No.:	<input type="text"/>		MICR Code: <input type="text"/>

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 Arogya Supreme 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. <input type="checkbox"/> | (b) CDSL Insurance Repository Ltd. <input type="checkbox"/> |
| (c) Karvy Insurance Repository Ltd. <input type="checkbox"/> | (d) CAMS Repository Services Ltd. <input type="checkbox"/> |

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

My CKYC No. (Central Know Your Customer registry number) is (if available):

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

Place:

Signature of the Insured

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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:

Place:

Signature of the Insured

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/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.

Nationality: Indian Non-Indian Non-Indian (please specify the Country)

Type of Organisation:

Corporation Government Non-Governmental Organisation Society Trust
 Partnership International Organisation Cooperative Section 8 Companies

Signature

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 Proposer 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 Policy issuance, not covered 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 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.

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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
6. I/we aware of premium loading, (if any declared above) for habits & diseases as declared / mentioned by me or us above.

Date:

D	D	M	M	Y	Y	Y	Y
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Place:

Signature of 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
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Place:

Signature of the Proposer

Agent Declaration:

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized 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 which 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 furthermore 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
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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

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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 or 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 on 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.

Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Rupees Ten Lakhs.

Insurance is subject matter of solicitation.

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