PROPOSAL FORM

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

HOSPITAL DAILY CASH INSURANCE POLICY

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 Insured 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 the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or anyone acting on Proposer's behalf. Kindly contact SBI General Offices or Agents for any doubts or clarifications on the proposal form.

Important Information: Health Check Up/ Medical Examination will be required for acceptance of the proposal based on the Medical history, Sum Insured & age of the Proposer as per our guidelines. For all persons aged 60 and above, medical examination is compulsory, irrespective of the Sum Insured opted and pre-acceptance medical tests 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 Rural Social

Business Type: New Roll-Over Renewal

Sales Channel Type: Banca Agency Direct

Sales Channel Code: Specified Person's Code*:

Specified Person's Name*: GSTIN/ISDN: IF APPLICABLE

PART I - PROPOSER (* Mandatory Fields)

1.* Do you have existing relationship with SBI General Insurance? Yes No If Yes, then please mention the Customer ID:

2.* Title: Mr. Miss Mrs. 3.* Name:

4.* Gender: Male Female Other 5. Marital Status: Married Single 6.* Date of Birth: D D M M Y Y Y Y

7.* Unique Identification (minimum one is required): PAN Card Ration Card Passport Biometric Card Gov ID Voter's ID Driving Licence

8.* Unique Identification No.: 9. Aadhaar Card No.:

10.* What industry do you work in? PAN No.: / Form 60/61.:

11.* Occupation: Salaried Self Employed/ Professional Business Student Retired Agriculture & allied Others (specify_____)

12.* Nationality:

13. Tel. Details: Landline No.: Mobile No.*:

14.* Preferred Contact Mode (Please Tick ✓): Email Paper Mail Phone 15. Email Address:

16. Period of Insurance: From D D M M Y Y Y Y To D D M M Y Y Y Y 17. Preferred Payment Mode: EFT Cheque

18.*Proposer's Permanent Residential Address:

City: Pincode:

19. Nominee's Name:

20. Nominee's Date of Birth: D D M M Y Y Y Y 21. Nominee's Relationship with the Primary Insured:

Appointee's Name: Appointee's Relationship with Nominee:

(In case Nominee is a minor)

22. Are you one among the Insured Persons Covered below? Yes No 23. Total number of persons to be covered:

ACKNOWLDEGEMENT SLIP (Tear Off):

This is to certify that the amount of ₹ _____ will be debited from the Bank Account No. _____ of Mr./Ms./Mrs._____ towards premium for SBI General's Hospital Daily Cash Insurance Policy.

Signed at:_____ Journal No.:_____ Authorised Signatory for SBI General

Signature: _____ Journal Date: D D M M Y Y Y Y _____

24. Details of Person/Member proposed for Insurance: (Please note, the Sum Insured for other family members cannot exceed the Sum Insured of Primary Insured).

Particulars	Primary Insured	Spouse	Child 1	Child 2
Name:				
Gender: M/F				
Date of Birth (DD/MM/YYYY):				
Relationship with the Proposer:				
Height (in Metres):				
Weight (in Kilograms):				
Occupation:				
Nationality:				
Gross Monthly Income:				
Marital Status:				
Educational Qualification:				
Benefit Amount/Sum Insured ₹:	☐ 500/day ☐ 1000/day	☐ 500/day ☐ 1000/day	☐ 500/day ☐ 1000/day	☐ 500/day ☐ 1000/day
	☐ 1500/day ☐ 2000/day	☐ 1500/day ☐ 2000/day	☐ 1500/day ☐ 2000/day	☐ 1500/day ☐ 2000/day
Sum Insured Option:	☐ Individual ☐ Individual with family			
Sum Insured Plan:	☐ 30 Days ☐ 60 Days			

25. Corporate: ☐ Yes ☐ No

26. GSTIN/ISDN: IF APPLICABLE

PART II - OTHER / CURRENT HEALTH INSURANCE INFORMATION

IMPORTANT NOTE: Please provide details of any Hospital Daily Cash Cover that you hold with SBI General Insurance Company Ltd. or any other Insurance Company. Please note that the information provided hereunder has a bearing on the admissibility of the claim, if any under the Policy proposed and hence request you to provide complete and exact information.

1. Do you hold or have any other Health Insurance Policies other than the one being proposed now, either with us or with other Insurers covering the Individuals proposed for Insurance now? ☐ Yes ☐ No
2. If any of the individual proposed for cover are not Covered earlier but are being proposed now, please provide full details of the same.

Name of the Individual	Date of birth	Relationship with the Primary Insured

3. If the answer to (1) is Yes, please provide the details of the Policies including details thereof in the below table and also provide complete details about the Individual not covered earlier but is being provided now as in a separate page/sheet.

Year	Insurance Company Name	Policy No.	Period of Insurance	Sum Insured	Special terms of acceptance/Exclusion under Policy (if any)	Claims Received

PART III - PERSONAL HEALTH DETAILS (To be filled in respect of all the members proposed to be covered under the policy)

Sr. No.	Details	Insured
1	Are you in good health and free from physical and mental diseases or infirmity or medical complaints or deformity?	Yes / No
2	Lifestyle details of the Insured:	
2a	Is your occupation associated with any specific hazard? (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals etc.)	Yes / No
2b	Do you consume tobacco in any form? If Yes, whether it is: Cigarette/Beedi/Cigar/Gutka/Pan Masala/Others.	Yes / No
	Quantity per day:	
	Consuming for past:	_____years
	If you have stopped smoking or using tobacco products then please mention from when?	

ACKNOWLDEGEMENT SLIP (Tear Off):

Note: (1) You shall receive the Policy copy on acceptance of your Proposal Form to the Head Office of SBI General Insurance Company. (2) Irrespective of the number of accounts the Insured has with SBI, he/she is allowed to take only one Policy. Multiple Policies for the same Insured are disallowed. (3) Even if multiple Policies are taken through one or more than one account with SBI for any reason, our liability will be restricted to only one Policy with the highest Sum Insured. All other Policies shall be deemed as null and void. Premium paid for all such Policies by Insured will be refunded after deduction of administrative expenses of ₹150. (4) In case of a Joint Account, two separate Policies may be issued in case both the account holders opt for respective Individual Policies. (5) Period of Insurance shall be 1 year from the date of transaction. (6) This acknowledgement slip does not in any way communicate the acceptance or commencement of risk under the application submitted by you. This is only an acknowledgement slip and is not the premium receipt. This acknowledgement slip should not be used for Income Tax purpose. The premium receipt shall be issued once the Company accepts the risk on your health and the amount deposited is applied to your Policy as premium. (7) Premium will be refunded in case your proposal is rejected by us. (8) For any assistance/ clarification required, kindly get in touch with SBI General Insurance Company Ltd. on 1800 22 1111, 1800 102 1111 (Toll Free).

Sr. No.	Details	Insured
2b	Do you consume alcohol? If Yes, type of alcohol: Beer/Hard liquor/Wine/Others:	Yes / No
	Amount consumed per week:	
	Consuming for past:	_____years
	If you have stopped drinking then please mention from when?	
3	Have you ever suffered or taken treatment or have been recommended to take medication for the following by a medical practitioner?	Yes / No
3a	High Blood Pressure/Heart Attack/Cardiovascular disease, Diabetes, Tuberculosis, Asthma, or other Respiratory Disease, Kidney disorder, Bladder disorder, Urine abnormality, Renal stones or Genital organ disorder, Cancer or any form of Tumour or Lump, Cyst growth, Liver and Gall bladder disorder, Stomach or Duodenal disorder, Fistula, Piles, Hernia, Eye, Ear, Nose, Throat or Endocrine diseases, Diseases of bones, joints or spine, Stroke, Eplilepsy or any other disorder of Brain, Spinal cord or Nerves.	Yes / No
3b	Any other illness/injury requiring investigation or treatment	Yes / No
	If answer to 3a or 3b is 'Yes', provide details of the ailment and nature of treatment in the Annexure.	
4	Have you ever been tested positive for HIV/AIDS , Hepatitis B or C or sexually transmitted diseases?	Yes / No

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want Hospital Daily Cash Insurance 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).

PAYMENT DETAILS

Journal Entry No.: Journal Entry Date: D D M M Y Y Y Y

Bank A/C No.:

Premium Amount in figures (including Goods and Services Tax as applicable)_____ Amount in Words:_____

Bank Branch:_____ Branch Office Code: _____

Signed at: _____ Signature: _____ Authorised Signatory for SBI: _____

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

Nationality: Indian/Non- Indian

If Non-Indian, please specify the Country: _____

Type of Organisation: Corporation/Government/Non-Governmental Organisation/Society/Trust/Partnership/ International Organisation/Cooperative/Section 8 Companies.

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.

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.

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

PROPOSAL FORM

HOSPITAL DAILY CASH INSURANCE POLICY

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Annexure to Hospital Daily Cash Insurance Policy

Sr. No.	Particulars	Details
1.	Name of the Insured:	
2.	Name & Address of the treating Doctor:	
3.	Nature of the Ailment (Exact Diagnosis):	
4	Date of the First Diagnosis:	
5.	Nature of Symptoms (Onset, Duration and Intensity):	
6.	List of Prescribed Medication:	
7	Further planned consultation (if any):	
8.	Details of Investigations performed along with the Dates and Results:	