PROPOSAL FORM

Super Health Insurance

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Important Guidelines

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

Office Use Only

Branch office Code:

Branch Name:

Business Type: New ☐ Roll-Over ☐ Renewal ☐ Migration ☐

Sales Channel Type: Banca ☐ Agency ☐ Direct ☐ Broker ☐

POS ☐ CSC ☐ Corporate Agent ☐ IMF ☐

Intermediary Details

Intermediary Name: FIRSTNAME MIDDLENAME SURNAME

Intermediary Code: Intermediary Contact Details:

Proposer Details

Name of the Proposer*: FIRSTNAME MIDDLENAME SURNAME

Communication Address*:

City: State:

Pin-Code: Landmark:

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

Date of Birth*: DDMMYYYY

Period of Insurance: From: DDMMYYYY to DDMMYYYY

Gender* : Male ☐ Female ☐ Others ☐

Marital Status*: Married ☐ Unmarried ☐ Divorced ☐ Widow(er) ☐

Email ID*:

PAN*: Form 60: if available ☐

AADHAAR No.:

Passport / Driving License/ Voter Id:

Profession: Salaried ☐ Self-Employed ☐ Other ☐ Details

Occupation and Nature of Business/ Work*:

Annual Gross Income:

Contact Details*: Mobile No.: Alternate Mobile No.:

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 ☐

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

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
Prime	3 Lacs ☐ 5 Lacs ☐ 7 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐
Elite	3 Lacs ☐ 5 Lacs ☐ 7 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐
Premier	3 Lacs ☐ 5 Lacs ☐ 7 Lacs ☐ 10 Lacs ☐
Platinum	10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐ 30 Lacs ☐ 40 Lacs ☐ 50 Lacs ☐
Platinum Infinite	50 Lacs ☐ 75 Lacs ☐ 1 Crore ☐ 2 Crores ☐

OPTIONAL COVERS - PLEASE TICK (✓)

Optional Covers	Sum Insured / Sub Limit
Enhanced ReInsure Benefit	Unlimited up to 200% ☐ [Enhanced ReInsure Benefit is not available for Platinum Infinite Plan]
Enhanced Cumulative Bonus Safeguard (If claim amount is 1Lac or less, No reduction in Enhanced Cumulative Bonus)	*Enhanced Cumulative Bonus Safeguard ☐ [This cover is not available for Platinum Infinite Plan]
Co-payment	10% ☐ 20% ☐
Aggregate Deductible	See table below

Plan	Deductible
Prime	1 Lac ☐ 2 Lac ☐ 3 Lac ☐
Elite	1 Lac ☐ 2 Lac ☐ 3 Lac ☐
Premier	1 Lac ☐ 2 Lac ☐ 3 Lac ☐
Platinum	3 Lac ☐ 5 Lac ☐
Platinum Infinite	5 Lac ☐ 10 Lac ☐

Domestic help/staff Indemnity (If this optional cover is opted please fill in the details in corresponding section^)	₹ 50,000 ☐ ₹ 1,00,000 ☐
Additional Basic Sum Insured for Accident (RTA) related hospitalization	2X (Twice the Sum Insured) ☐
Wellness Benefit*	☐ Health Assistance (A.I Personal Fitness Coaching), Dietician and Nutrition E–Consultation, and Unlimited Gym Membership ☐ Walk Healthy Benefit

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 (DD/MM/YYYY) *^						
Age*						
Gender*						
Marital Status*						
Height (in cms)*						
Weight (in Kgs)*						
Nationality*[Indian/ Non-Indian (In case of Non-Indian, please provide nationality details)						
Occupation and Nature of Business/ Work*						
Relationship with the Proposer*						
Basic Sum Insured (Separate only for Individual cover)						
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 ☐

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)

^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 proposer, any payment due under the policy shall become payable to the nominee and the receipt of the proceeds by such nominee would be sufficient discharge to the company. For all other persons covered under the policy, the proposer will be the nominee. Nominee must be immediate relative (Mother, Father, Spouse, Son, and daughter) of 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	Address of Appointee	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 Insurance Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Policy Number						
Insurer Name						
Period of Insurance						
Sum Insured (in Rs.)						
Claim Details (if any)						
Cumulative Bonus (if any, in Rs.)						

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	Name of Illness/ disease/ Injury/ Disability	Duration since suffering from	Medications details (present/ past) please specify	Are you fully cured- Yes/No?
Insured 1				
Insured 2				
Insured 3				

Insured 4				
Insured 5				
Insured 6				

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 Proposer

Details of the Family Doctor:

Name of the Doctor: SURNAME MIDDLENAME FIRSTNAME

Mobile No. or Contact No.:

Register No. of the Family Doctor:

Premium Payment and Bank Account Details:

Premium Amount: (in figure) ₹ (in words)

Name of Premium Payer:

Premium Payment Frequency: Monthly Quarterly Half Yearly Annual Premium Single Premium

Premium payment mode option: Cheque DD Debit Card/Credit Card

Bank Account Number: Bank Name: _____

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

IFSC Code: Branch Name:_____ Card Details: Master Visa

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

Relationship with Proposer_____

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 were 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.

Name as in Bank Account IFSC Code:

Bank Account No Amount

Bank Name Cheque Date: D D M M Y Y Y Y

Cheque No.: MICR Code: Branch Name:

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.

Place :_____

Electronic Insurance Account Details:

I Want Super Health Insurance

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

I would like to apply for eIA with

(a) NSDL Data Management. (b) CSDL Insurance Repository Lt.

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

My CKYC No. (Central Know Your Customer Registry Number), (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 Proposer

Renewal Payment Sign-up:

Payment of renewal premium of your health insurance Policy can be made every year through 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 Proposer

AML GUIDELINES

I/ We hereby confirm that all premiums have been/ will be paid from bonafide 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 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 Country: _____

Type of Organization: ☐ Corporations ☐ Governments ☐ Non-Governmental Organizations ☐ Society ☐ Trust ☐ International Organization ☐ Partnership ☐ Cooperatives ☐ Section 8 Companies

I hereby declare that the current address is different from the available 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 Proposer 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 is not covered under this policy (Your proposal form will be considered

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.
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 Regulatory authority."
6. I/we aware of premium loading, (if any declared above) for diseases as declared / mentioned by me or 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

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 Proposer

Additional Declarations Pertaining To Wellness Benefits# & Value Added Benefits (Vas)

I / We agree that on the issuance of the Policy, I / We will provide the Company with all relevant details relating to the tracking device and / or mobile app downloaded at the earliest. I / We understand and agree that these details are required by the Company to track, record and calculate my / our eligibility for the Wellness Benefits / Value Added Services under the Policy. I / We declare and consent through my / our own free will and without any duress that the Company may access and record these details on a periodic basis and use these details for calculating and according these Benefits under the Policy. I / We further declare and consent that the information / data provided herein shall be used by the service provider(s) / vendors / third party for the limited purpose of extended these benefits. I / We further declare and consent that the benefits extended hereinunder shall be at the sole discretion of the service provider(s) / vendors / third party only. I / We further declare and consent that the original reports pertaining to any health assessments or tests undertaken by me / us in order to determine the eligibility to avail or continue to avail the Wellness Benefits under the Policy will be handed over by the concerned network providers directly to the Company and will remain on the Company's records.

Date: D D M M Y Y Y Y

Place :

Signature of 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 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.

Agent Name:

SP Name:

SP Code:

License No.:

Date: D D M M Y Y Y Y

Place :

Signature of 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)_____ (Relation 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 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 policy are kept confidential and will not be shared with any external party in any circumstances whatsoever. Ho

wever, 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 direction 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 misrepresentation, 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 or the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which 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

1. 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.
2. Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Rupees Ten Lakhs.

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 Officer	Percentage (%)*	Remarks, if any

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 eans.

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 **fifteen 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: