

“SBI HEALTH ASSIST” SCHEME

GROUP MEDICLAIM POLICY ‘B’ FOR SBI RETIREES

APPLICATION FORM FOR NEW MEMBERS

Policy ‘B’ (16.01.2024 – 15.01.2025)

Date of payment of premium	
Journal No.	
Amount paid	

Chief Manager
State Bank of India,
Branch / Administrative office,

Dear Sir,

Affix coloured joint photograph
of the member and spouse

SUB: SBI Health Assist Group Health Insurance Policy for SBI Retirees

Policy Period: 16.01.2024 – 15.01.2025

I am interested in joining the Family Floater Group Health Insurance Policy of State Bank of India (Policy B – SBI Health Assist Scheme) and furnish the required information as under:

Sl.	Particulars	Remarks
1 A	P.F Index No./ HRMS ID	
1 B	PF ID (for pre-merger retirees of e-Abs who don't have HRMS ID) for example “ SBM1234/ SBH1234, SBP1234..... ”	
2	Name of retiree / Family pensioner	
3	Date of Birth of retiree / Family pensioner	dd/mm/yyyy
4	Date of joining the Bank	
5	Date of Retirement	

6	Date of Death of deceased employee/ pensioner (applicable for Family pensioners)	
7	Retired as Clerical/Sub-staff/JMGS-I/MMGS-II/MMGS-III/SMGS-IV/SMGS-V/TEGS-VI/TEGS-VII/TEGSS-I/TEGSS-II	
8	Age (in years) as on the date of retirement	
9	Gender	i. Male ii. Female
10	Type (please write Pensioner / Family pensioner / Retiree)	
11	Category (Please tick mark)	<ul style="list-style-type: none"> i. SBI retirees on completion of pensionable service in the Bank. ii. Surviving spouses of SBI employee who died whilst in service or after retirement. iii. Existing members of SBI Health care / Policy-A. iv. Old retiree/ surviving spouses / family pensioners of erstwhile Associate Banks of SBI (e-ABs) v. Pensioners removed from service and receiving pension. vi. Pensioners / Retirees who could not join 'SBI Health Assist' in the Policy year 2023-24
12	Whether dismissed or terminated from service. (Tick)	Yes / No
13	Whether Rule 19(3) was invoked on attaining the age of retirement (If yes, please furnish the details of the disciplinary case, date of its conclusion and penalty, if any imposed)	Yes / No
14	Address for communication	Address
		Nearest Landmark
		Post Office
		City / District

		State										
		Pin Code										
15	Landline No. (with STD code)											
16	Mobile No. (it will be used for registration under e-Pharmacy scheme)											
17	Alternate Mobile no. (if any)											
18	Email ID											
19	Name of Spouse (if any)											
20	Date of Birth of Spouse (dd/mm/yyyy)											
21	Name of disabled Child / Children (if any) (As declared to the Bank)	Sl	Name of the disabled child	Date of Birth (dd/mm/yyyy)	Gender							
		1.										
		2.										
22	Name of the pension/family pension paying branch	Name of the Branch					Branch Code No.					
23	Pension Account No. (11 digit)											
24	IFSC Code											
BASIC COVER PLANS												
25	Sum Insured	Basic Premium (Annual)	GST @ 18%	Gross Premium (A)	Please Tick Opted Plan							
	3,00,000	17,343	3,121.74	20,465.00								
	5,00,000	38,552	6,939.36	45,491.00								
ADDITIONAL SUPER TOP-UP COVER**												
26	Base plan	Sum Insured of Additional Super top-up	Basic Premium (Annual)	GST @ 18%	Gross Premium (B)	Please Tick Opted Plan						
	3,00,000	11,00,000	5,266.00	9,47.88	6,214.00							
		16,00,000	6,531.00	1,175.58	7,707.00							
		21,00,000	8,572.00	1,542.96	10,115.00							

	5,00,000	14,00,000	9,992.00	1,798.56	11,791.00	
		19,00,000	11,420.00	2,055.60	13,476.00	
		29,00,000	17,431.00	3,137.58	20,569.00	
		39,00,000	23,441.00	4,219.38	27,660.00	
CRITICAL ILLNESS COVER **						
27	Sum Insured	Basic Premium (Annual)	GST @ 18%	Gross Premium (C)	Please Tick if applied	
	5,00,000	14,441	2599.38	17,040.00		
<p>** Critical Illness Cover and Additional Super top-up cover will not be available separately and can be taken only with a Base Plan</p> <p>**Members aged below 65 years as on 15th January 2024 to opt for Critical illness Plan</p> <p>N.B.: Pro-rata premium for new retirees will be applicable in all the plans i.e. Basic Cover Plans, Additional super top up and Critical Illness Plans.</p> <p>Employees retiring during currency of the policy should apply by paying the pro-rata premium within 90 days from the date of their retirement.</p>						
28	CALCULATION OF TOTAL PREMIUM (with GST)					
	Premium for Base Plan	Premium for Additional Super top-up Plan (if any)	Premium for Critical Illness (if any)	Total Premium Paid (with GST)		
	(A)	(B)	(C)	A + B + C		
29	<p>The information regarding all four vendors is uploaded on https://sbi.co.in/web/personal-banking/pension-seva . Kindly go through the document containing the services offered by each vendor and then select a vendor of your preference.</p> <p>Selection of e-Pharmacy Vendor (Any one) –</p> <ol style="list-style-type: none"> 1. Medibuddy 2. Pharmeasy 3. Tata IMG 4. Ur Life <p>I hereby select vendor M/S_____ as my e-Pharmacy vendor for providing services during Policy year 2024-25. To enable the vendor so selected to allow access to the services offered by them, I authorize the Bank to share my PF ID/ contact details and details of my/ my family members to such vendor, for which I give my consent herewith.</p>					

30. Declaration Nominee/s :

I, Mr./Mrs./Ms. _____, a pensioner of the Bank/ a retired employee / spouse of the deceased employee do hereby assign the money payable by “**SBI General Insurance Co. Ltd.**” in case of my death to Mr. / Mrs./ Ms. _____ Relation _____ and further declare that his/her receipt shall be sufficient discharge of the company.

31. Debit Authority for Super Top-up Premium

I hereby authorize Bank to credit and debit premium of Super Top-up cover of 6 Lacs from my pension.

32. Debit Authority:

I am aware that I along with my spouse and disabled child/children (if any, as declared to Bank) will be eligible for a health insurance cover under the Family Floater Group Health Insurance 'Health Assist'. I hereby authorize the Bank to debit the insurance premium amount of Rs. _____ to my pension / family pension account No. _____.

I undertake to keep sufficient balance in my above account for debiting insurance premium for the policy year 2024-25 failing which the policy may not be issued to me. I am also aware that Bank may at its sole discretion can modify the terms and conditions of the policy from time to time.

33. Undertaking:

I am desirous of availing the “SBI Health Assist” Scheme (“Services”) offered by the Bank through third-party agencies/service providers/vendors (“Third Party Entities”). The Bank may also at its sole discretion offer certain additional services, (information regarding such service/s will be Circulated subsequently by Bank) (“Additional Services”) through Third Party Entities selected by the Bank. For the purpose of rendering Services and/or Additional Services, I do hereby expressly authorize the Bank to share, disclose or exchange my PF ID/ contact details and details of my/ my family members to Third Party Entities.

I understand that availing of Additional Services will be on voluntary and chargeable basis.

I undertake that I will use aforesaid additional services for my genuine personal purpose and for the declared family members only. In case of any misuse of the facility is reported and/or the facility is used for commercial purposes, Bank/ Third Party Entities are free to take appropriate measures including to suspend the services if so warranted.

Also, I undertake that any liability, damage, claim, loss etc. that the Bank may suffer or incur, on account of any acts of omission on my part in connection with the use of Additional Services, shall be recoverable from me on first demand made by the Bank.

I understand that the Additional Services are provided by Third Party Entities and any issues/concerns related thereto need to be taken up with Third Party Entities only. The Bank shall not be responsible for any loss incurred by me on account of use of such Additional Services provided by Third Party Entities.

I have read, understood and accept the contents of this 'Consent-cum-Undertaking'.

Place :

Date :

Signature of Retired Employee / Spouse

For office use only

Certified that Shri / Smt. _____ is a retired employee / spouse of the retired / deceased employee of SBI / e-ABs and he / she has remitted the insurance premium in Mediclaim Collection Account No. _____ of Administrative Office as per the following details:

Transaction No. (Journal No.)

Date : _____

Amount : _____

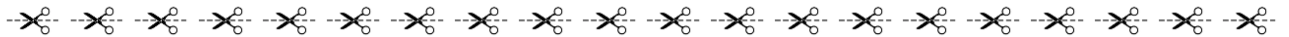
State Bank of India

Name of the Forwarding Branch (Code No.) :

Place :

Date :

Signature of the Branch Manager with seal



ACKNOWLEDGEMENT OF PREMIUM PAID

Name of the applicant – PF ID -- Base plan – Additional Super Top-up Plan (if applied) -- Critical illness Plan (if applied)-- Application Submitted on:	<p>For Branch use only</p> Premium paid – Date of Transaction –
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Signature of the Branch Manager with seal

(On Branch Letter head)

ACKNOWLEDGEMENT OF PREMIUM PAID

(Year 2024-25)

'SBI HEALTH ASSIST'

GROUP MEDICLAIM POLICY FOR RETIREES

(to be given to the applicant by the Branch receiving this Application Form)

Received from Shri/Smt. _____

PF Index No. _____

This is to certify that Insurance Premium including GST for Rs _____

(Base Plan/ Additional Super Top-up / Critical Illness Cover) + Rs. 8,202 (Annual Premium for Super Top-up Cover of 6 lacs) = Rs. _____

(in words Rupees _____

_____) has been received for enrolment in Mediclaim Collection

Account No _____ of Administrative Office for the above Mediclaim Policy.

Date _____

Signature of the Branch official issuing the certificate