ANNEXURE-I

"SBI Health Assist" Scheme

GROUP MEDICLAIM POLICY FOR SBI RETIREES
ANNUAL PAYMENT PLAN (APP)

APPLICATION FORM FOR APP (01-11-.2020 – 15.01.2021)

Date of payment of premium	
Journal No,	
Amount paid	

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

Affix coloured joint photograph of the member and spouse

Dear Sir,

SUB: Family Floater Group Health Insurance Policy for SBI Retirees
Policy Period : 16.01.2020 – 15.01.2021

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

Sl.	Particulars	Remarks
1A	P.F Index No. / HRMS ID (for post merger e-ABs retirees)	
1B	PF ID (for pre merger retirees of e-ABs) for example **"1234 SBM / SBH……."**	
2	Name	
3	Date of joining the Bank	
4	Date of Retirement	
5	Retired as	**Clerical/Sub-staff/JMGS-I/MMGS-II/MMGS-III/SMGS-IV/SMGS-V/TEGS-VI/TEGS-VII/TEGSS-I/TEGSS-II**
6	Age (in years) as on the date of retirement	
7	Gender	**i. Male**

		ii. Female	
8	Type **(please write Pensioner / Family pensioner / Retiree)**		
9	Category (Please tick mark)	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 Policy-A. iv. Old retiree/ surviving spouses / family pensioners of erstwhile Associate Banks of SBI (e-ABs)/Existing members of IBA Policy v. Pensioners removed from service and receiving pension. vi. Pensioners / Retirees who could not join Policy-B in the past and now wish to join.	
10	Whether dismissed or terminated from service. (Tick)	Yes / No	
11	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	
12	Date of Birth	dd/mm/yyyy	
13	Date of Death (in case of deceased employee / pensioner)	dd/mm/yyyy	
14	Address for communication	**House No.**	
		Building name	
		Street name/Area name	
		Nearest Landmark	
		Post Office	
		City	
		State	
		Pin Code	
15	Landline No. (with STD code)		
16	Mobile No.		
17	Email ID		
18	Name of Spouse (if any)		
19	Date of Birth of Spouse (dd/mm/yyyy)		
20	Name of disabled Child / Children (if any).	**Sl**	**Name of the disabled child** / **Date of Birth**
		1.	
		2.	

	(Attach valid disability certificate issued by medical officer not below the rank of Civil Surgeon)			
21	Name of the pension/family pension paying branch	**Name of the Branch**		**Code No.**
22	Pension Account No. (11 digit)			
23	IFSC Code			

BASIC COVER PLANS

24	Sum Insured	Basic Premium Pro-rata(50%)	GST @ 18%	Gross Premium (A)	Please Tick Opted Plan
	3,00,000	8271	1489	9760	
	5,00,000	18386	3309	21695	

CRITICAL ILLNESS COVER **

25	Sum Insured	Basic Premium	GST @ 18%	Gross Premium (B)	Please Tick
	5,00,000				

**** Critical Illness Cover will not be available separately and can be taken only with a Base Plan.**

N.B. : Pro-rata premium for new retirees will be applicable in both the plans i.e. Basic Cover Plans and Critical Illness Plan.

26	CALCULATION OF TOTAL PREMIUM (with GST)		
	Premium for Base Plan	Premium for Critical Illness (if any)	Total Premium Paid (with GST)
	(A)	(B)	A+B = C

27 Declaration of Nominee/s :

I, Mr./Mrs./Ms. _____ , a retired employee / spouse of the deceased employee / pensioner of the Bank 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.

28. Debit Authority :

I am aware that I along with my spouse and disabled child/children (if any) will be eligible for a health insurance cover of Rs. _____ lakhs under the Family Floater Group Health

Insurance Policy. 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 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.

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 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

"SBI Health Assist"

GROUP MEDICLAIM POLICY FOR RETIREES
ANNUAL PAYMENT PLAN (APP)

(to be given to the applicant by the branch receiving the Form)

Received from Shri/Smt._____

PF Index No._____

Application for membership of Family Floater Group Mediclaim Policy (APP) along with Insurance Premium including GST for Rs._____ for onward submission to Administrative Office.

Date _____

Branch _____ Stamp of the Branch Signature of the officer receiving the Form