ANNEXURE-II

"SBI Health Assist" Scheme

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

CONSENT FOR RENEWAL (2021 - 22)

Date of payment of premium	
Journal No,	
Amount paid	

The Branch Manager
State Bank of India,
_______________________ Office/ Branch

Dear Sir,

SUB: Family Floater Group Health Insurance Policy for SBI Retirees, Policy Period : 16.01.2021 – 15.01.2022

PF No.		
Name of Pensioner/ Spouse of Deceased Pensioner	Gender (M/F)	Dt. of Birth (dd/mm/yyyy)
Name of Spouse	Gender (M/F)	Dt. of Birth (dd/mm/yyyy)
Name of disabled child (if any) 1. 2.	Gender (M/F)	Dt. of Birth (dd/mm/yyyy)
Name of the Nominee	Relationship of Nominee	
Date of Retirement :		
Pensioner Type (Pensioner / Retiree / Family Pensioner)		
Address of pensioner		

City	
State	
Pin code	
Mobile No. / Landline No.	
Email Id.	
Name of Zonal /Administrative office	

Name of LHO	
Name of Pension Branch	
Pension Branch code	
Pension Account no.	
IFSC code	
Date of payment of premium (dd/mm/yyyy)	

I intend to join the Family Floater Group Health Insurance under Annual Payment Plan of State Bank of India. I hereby exercise my options as per the following :

Sum Insured (Rs in Lakhs)	**Premium details for Basic Cover (Without Domiciliary)**			
	Basic Premium	**GST @ 18%**	**Gross Premium (A)**	**Please Tick Opted Plan**
3,00,000	**16,542**	**2,978**	**19,520**	
5,00,000	**36,771**	**6,619**	**43,390**	

Sum Insured	**Basic Premium**	**GST @ 18%**	**Gross Premium (B)**	**Please Tick Opted Plan**
5,00,000**	**13,774**	**2479**	**16253**	
****Critical Illness Cover will not be available separately and can be taken only with a base plan.**				

Calculation of Total Premium :

Premium for Basic Plan Opted with GST (A)	**Critical Illness Plan Premium (If any) with GST (B)**	**Total Premium (with GST) A+B = C**

Debit Authority :

I am aware that I along with my spouse and disabled child/children 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 / Savings Bank Account No. ___________________.

Date : **Signature of Retired Employee/ Spouse**

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 / HRMS 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