## ANNEXURE-I

## **GROUP MEDICLAIM POLICY FOR SBI RETIREES (POLICY-B)**

## APPLICATION FORM FOR POLICY-'B' (16.01.2017 - 15.01.2018)

Chief Manager State Bank of India, Zonal office,

Affix coloured joint photograph of the member and spouse

Dear Sir,

## SUB: Family Floater Group Health Insurance Policy for SBI Retirees Policy Period: 16.01.2017 – 15.01.2018

I am interested in joining the Family Floater Group Health Insurance Policy 'B' of State Bank of India and furnish the required information as under:

SI.	Particulars		Remarks
01	P.F Index No.		
02	Name		
03	Name of the Bank		SBI/e-SBS/e-SBIN
04	Date of joining the Bank		
05	Date of confirmation in service		
06	Date of Retirement		
07	Retired as		al/Sub-staff/JMGS-I/MMGS-II/MMGS- GS-IV/SMGS-V/TEGS-VI/TEGS-VII/TEGSS- SS-II
08	Age (in years) as on the date of retirement		
09	Gender	i.	Male
		ii.	Female
10	Туре	i.	Pensioner
		ii.	Family Pensioner
11	Category (Please tick mark)	i.	SBI retirees on completion of pensionable service in the Bank.
		ii.	Members of National Pension System on completion of 20 years of confirmed service in the Bank.
		iii.	Spouse of SBI employee who died whilst in

			iv. Pre-merger re completed the conce v. Surviving spot /decease SBIN. vi. Existing mem and e-SBI	on of pension erned Bank. ouses of pre- ed employees ber of SBIREM NREMBS. emoved from	ent. S and e-SBIN on hable service in merger retirees of e-SBS and e- BS, e-SBS REMBS on service and	
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	Date of Birth		(	dd/mm/yy		
15	Date of Death (in case of deceased employee / pensioner)	dd/mm/yy				
16	Address for communication	Street New Post Political City Star				
17	Landline No. (with STD code)	rin	Code			
18	Mobile No.					
19	Email ID					
20	Name of Spouse (if any)					
21	Date of Birth of Spouse			dd/mm/yy		
22	Name of disabled Child /	SI Name of the disable			Date of Birth	
	Children (if any).			The Country of the Co	dd/mm/yy	
1	(Attach valid disability				dd/mm/yy	
	certificate issued by medical officer not below the rank of Civil Surgeon)				dd/mm/yy	
23	Name of the pension/family		Name of the I	Code No.		
	pension paying branch					
24	Pension Account No. (11 digit)					
25	IFSC Code					

26 Sum Insured opting for (Please tick the	SI	Plans	Sum Insured	Premium	ST + Cess	Total (Rs.)
appropriate	1	A	Rs. 3.00 lac	15,836/-	2,375/-	18,211/-
scheme)	2	В	Rs. 4.00 lac	21,053/-	3,158/-	24,211/-
ST= Service Tax	3	С	Rs. 5.00 lac	27,173/-	4,076/-	31,249/-
@14% SBC= @ 0.5%	4	D	Rs. 7.50 lac	34,418/-	5,163/-	39,581/-
KKC= @ 0.5%	5	E	Rs. 10.00 lac	42,075/-	6,311/-	48,386/-
Total = 15%	6	F	Rs. 15.00 lac	63,368/-	9,505/-	72,873/-
	7	Н	Rs. 25.00 lac	116,268/-	17,440/-	133,708/-
Declaration of Nominee/s						
, Mr./Mrs./Ms.	•		, a retired em	nlovee / sr	ouse of th	ne deceased
employee / pensioner of the	he B					
Insurance Co. Ltd." in ca					20,000	
Relation					ceipt shall	be sufficient
discharge of the company						
Debit Authority :						
I am aware that I along w	ith r	ny spou	ise and disable	ed child/child	dren will be	eligible for a
health insurance cover	of R	s	lac unde	r the Family	y Floater C	Group Health
Insurance policy. I hereby	1 011	thorizo	the Bank to d	shit the ani	nual incura	nce premium
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