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:

Sl.	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	**Clerical/Sub-staff/JMGS-I/MMGS-II/MMGS-III/SMGS-IV/SMGS-V/TEGS-VI/TEGS-VII/TEGSS-I/TEGSS-II**
08	Age (in years) as on the date of retirement	
09	Gender	**i. Male** **ii. Female**
10	Type	**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

		service or after retirement. iv. Pre-merger retirees of e-SBS and e-SBIN on completion of pensionable service in the concerned Bank. v. Surviving spouses of pre-merger retirees /deceased employees of e-SBS and e-SBIN. vi. Existing member of SBIREMBS, e-SBS REMBS and e-SBINREMBS. vii. Pensioners removed from service and receiving pension.
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	**House No.** **Street No.** **Nearest Landmark** **Post Office** **Police Station** **City** **State** **Pin Code**
17	Landline No. (with STD 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 / Children (if any). (Attach valid disability certificate issued by medical officer not below the rank of Civil Surgeon)	**Sl** | **Name of the disabled child** | **Date of Birth** dd/mm/yy dd/mm/yy dd/mm/yy
23	Name of the pension/family pension paying branch	**Name of the Branch** | **Code No.**
24	Pension Account No. (11 digit)	
25	IFSC Code	

26	Sum Insured opting for (Please tick the appropriate scheme) **ST= Service Tax @14%** **SBC= @ 0.5%** **KKC= @ 0.5%** **Total = 15%**	**Sl**	**Plans**	**Sum Insured**	**Premium**	**ST + Cess**	**Total (Rs.)**
		1	A	Rs. 3.00 lac	15,836/-	2,375/-	18,211/-
		2	B	Rs. 4.00 lac	21,053/-	3,158/-	24,211/-
		3	C	Rs. 5.00 lac	27,173/-	4,076/-	31,249/-
		4	D	Rs. 7.50 lac	34,418/-	5,163/-	39,581/-
		5	E	Rs. 10.00 lac	42,075/-	6,311/-	48,386/-
		6	F	Rs. 15.00 lac	63,368/-	9,505/-	72,873/-
		7	H	Rs. 25.00 lac	116,268/-	17,440/-	133,708/-

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 **"United India 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.

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. _____ lac under the Family Floater Group Health Insurance policy. I hereby authorize the Bank to debit the annual insurance premium amount of Rs. _____ to my pension / family pension account No. _____ now and to renew the policy every year by debiting the renewal premium as communicated by the insurance company to my above account without further reference to me unless my intension not to renew the policy is informed to at least one month in advance of the renewal date. I undertake to keep sufficient balance in my above account for debiting current insurance / renewal premium failing which the policy may not be issued / renewed. I am also aware that Bank may at its sole discretion can modify the terms and conditions of the policies 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 the Bank 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**

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