**ANNEXURE-I**

***“SBI Health Assist” Scheme***

**GROUP MEDICLAIM POLICY FOR SBI RETIREES**

**ANNUAL PAYMENT PLAN (APP)**

**APPLICATION FORM FOR APP (16.01.2020 – 15.01.2021)**

|  |  |
| --- | --- |
| **Date of payment of premium** |  |
| **Journal No,** |  |
| **Amount paid** |  |

Affix coloured joint photograph

of the member and spouse

Chief Manager

State Bank of India,

Branch / Administrative office,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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  | 1. **Male**
2. **Female**
 |
| 8 | Type **( please write Pensioner / Family pensioner / Retiree)** |  |
| 9 | Category(Please tick mark) | 1. SBI retirees on completion of pensionable service in the Bank.
2. Surviving spouses of SBI employee who died whilst in service or after retirement.
3. Existing members of Policy-A.
4. Old retiree/ surviving spouses / family pensioners of erstwhile Associate Banks of SBI (e-ABs)
5. Pensioners removed from service and receiving pension.
6. 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).(Attach valid disability certificate issued by medical officer not below the rank of Civil Surgeon) | **Sl** | **Name of the disabled child** | **Date of Birth** |
| 1. |  |  |
| 2. |  |  |
|  |  |  |
| 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** | **GST @ 18%** | **Gross Premium (A)** | **Please Tick Opted Plan** |
| **3,00,000** |  |  |  |  |
| **5,00,000** |  |  |  |  |
|  |
| **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