**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