ANNEXURE-IV

"SBI HEALTH ASSIST" SCHEME (2024-25)

CONSENT FOR RENEWAL

Date of payment of premium	
Journal No.	
Amount paid	

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

Dear Sir,

SUB: SBI Health Assist Group Health Insurance Policy for SBI Retirees
Policy Period: 16.01.2024 –15.01.2025

PF No. /HRMS ID		
Pensioner Type (Pensioner / Retiree / Family Pensioner)		
Name of Retiree/ Spouse of Deceased Retiree (Family 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 - As declared to the Bank) 1. 2.	Gender (M/F)	Dt. of Birth (dd/mm/yyyy)
Name of the Nominee :	Relationship of Nominee :	
Date of Retirement :		
Address of pensioner :		

City	
State	
Pin code	
Mobile No. (For E-pharmacy Scheme)	
Landline No.	
Email Id.	
Name of Zonal/Administrative office	

Name of LHO	
Name of Pension Branch	
Pension Branch code	
Pension Account no.	
IFSC code	

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

Sum Insured (Rs. in Lacs)	**Premium details for Basic Cover**			
	Basic Premium (Annual)	**GST @ 18%**	**Gross Premium (Rounded off) (A)**	**Please Tick Opted Plan**
3,00,000	17,343	3121.74	20,465.00	
5,00,000	38,552	6939.36	45,491.00	

Premium details for Additional Super Top cover					
Base plan (Amt. in lacs)	**Additional Super Top-up** (Amt. in lacs)	**Basic premium (Annual)**	**GST @ 18 %**	**Gross Premium (Rounded off) (B)**	**Please Tick Opted Plan**
3.00	**11.00**	5266.00	947.88	6,214.00	
	16.00	6531.00	1175.58	7,707.00	
	21.00	8572.00	1542.96	10,115.00	
5.00	**14.00**	9992.00	1798.56	11,791.00	
	19.00	11420.00	2055.60	13,476.00	
	29.00	17431.00	3137.58	20,569.00	
	39.00	23441.00	4219.38	27,660.00	

Sum Insured	**Basic Premium (Annual)**	**GST @ 18%**	**Gross Premium (Rounded off) (C)**	**Please Tick Opted Plan**
5,00,000**	14,441	2599.38	17,040.00	

****Critical Illness Cover will not be available separately and can be taken only with a base plan.**

****Members aged below 65 years as on 15th January 2024 to opt for Critical illness Plan**

Calculation of Total Annual Premium :

Premium for Basic Plan Opted with GST (A)	Additional Super top-up Premium (If any) with GST (B)	Critical Illness Plan Premium (If any) with GST (C)	Total Premium (with GST) A+B+C = D

i) Selection of e-Pharmacy Vendor –

The information regarding all four vendors is uploaded on https://sbi.co.in/web/personal-banking/pension-seva . Kindly go through the document containing the services offered by each vendor and then select a vendor of your preference

1. **Medibuddy**
2. **Pharmeasy**
3. **TATA 1MG**
4. **Ur Life**

I hereby select vendor M/S_____as my e-Pharmacy vendor for providing services during Policy year 2024-25. To enable the vendor so selected to allow access to the services offered by them, I authorize the Bank to share my PF ID/ contact details and details of my/ my family members to such vendor, for which I give my consent herewith.

ii) Declaration of Nominee

I, Mr./Mrs./Ms. _____ , a pensioner of the Bank/ a retired employee / spouse of the deceased employee 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.

iii) Debit Authority for Super Top-up Premium (Sponsored by Bank)

I hereby authorize Bank credit and debit the annual premium of **Rs.8,202.00** for Super Top-up cover of 6 Lacs from my pension.

iv) 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. _____ lacs under the Family Floater Group Health Insurance policy 'B'. I hereby authorize the Bank to debit the insurance premium amount of Rs. _____to my pension / family pension account / Savings Bank Account No. _____.

2Undertaking:

I am desirous of availing the “SBI Health Assist” Scheme (“Services”) offered by the Bank through third-party agencies/service providers/vendors (“Third Party Entities”). The Bank may also at its sole discretion offer certain additional services, (information regarding such service/s will be Circulated subsequently by Bank) (“Additional Services”) through Third Party Entities selected by the Bank. For the purpose of rendering Services and/or Additional Services, I do hereby expressly authorize the Bank to share, disclose or exchange my PF ID/ contact details and details of my/ my family members to Third Party Entities. I understand that availing of Additional Services will be on voluntary and chargeable basis.I undertake that I will use aforesaid additional services for my genuine personal purpose and for the declared family members only. In case of any misuse of the facility is reported and/or the facility is used for commercial purposes, Bank/ Third Party Entities are free to take appropriate measures including to suspend the services if so warranted.

Also, I undertake that any liability, damage, claim, loss etc. that the Bank may suffer or incur, on account of any acts of omission on my part in connection with the use of Additional Services, shall be recoverable from me on first demand made by the Bank.

I understand that the Additional Services are provided by Third Party Entities and any issues/concerns related thereto need to be taken up with Third Party Entities only. The Bank shall not be responsible for any loss incurred by me on account of use of such Additional Services provided by Third Party Entities.

I have read, understood and accept the contents of this ‘Consent-cum-Undertaking’.

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 in Mediclaim Collection Account No. _____ of Administrative Office 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 OF PREMIUM PAID

Name of the applicant – PF ID -- Base plan – Additional Super Top-up Plan (if applied) -- Critical illness Plan (if applied)-- Application Submitted on:	**For Branch use only** **Premium paid –** **Date of Transaction –**

_____

Signature of the Branch Manager with seal

ACKNOWLEDGEMENT OF PREMIUM PAID

(Year 2024-25)

'SBI HEALTH ASSIST'

GROUP MEDICLAIM POLICY FOR RETIREES

(to be given to the applicant by the Branch receiving this Application Form)

Received from Shri/Smt._____

PF Index No._____

This is to certify that Insurance Premium including GST for Rs_____

(Base Plan/ Additional Super Top-up / Critical Illness Cover) + Rs. 8,202.00 (Annual Premium for Super Top-up Cover of Rs. 6.00 Lacs) = Rs. _____

(in words Rupees _____

_____) has been received for enrolment in Mediclaim Collection Account No _____ of Administrative Office for the above Mediclaim Policy.

Date_____

Signature of the Branch official

issuing the certificate