

**“SBI Health Assist” Scheme****GROUP MEDICLAIM POLICY ‘B’ FOR SBI RETIREES****APPLICATION FORM FOR Policy ‘B’ (16.01.2023 – 15.01.2024)**

<b>Date of payment of premium</b>	
<b>Journal No.</b>	
<b>Amount paid</b>	

Chief Manager  
State Bank of India,  
Branch / Administrative office,

Affix coloured joint photograph  
of the member and spouse

Dear Sir,

**SUB: Family Floater Group Health Insurance Policy ‘B’ for SBI Retirees****Policy Period : 16.01.2023 – 15.01.2024**

I am interested in joining the Family Floater Group Health Insurance Policy of State Bank of India (Policy B – SBI Health Assist Scheme) and furnish the required information as under:

<b>Sl.</b>	<b>Particulars</b>	<b>Remarks</b>
1 A	P.F Index No./ HRMS ID	
1 B	PF ID (for pre-merger retirees of e-Abs who don't have <b>HRMS ID</b> ) for example “ <b>SBM1234/ SBH1234, SBP1234.....</b> ”	
2	Name of retiree / Family pensioner	
3	Date of Birth of retiree / Family pensioner	dd/mm/yyyy
4	Date of joining the Bank	

5	Date of Retirement	
6	Date of Death of deceased employee/ pensioner (applicable for Family pensioners )	
7	Retired as <b>Clerical/Sub-staff/JMGS-I/MMGS-II/MMGS-III/SMGS-IV/SMGS-V/TEGS-VI/TEGS-VII/TEGSS-I/TEGSS-II</b>	
8	Age (in years) as on the date of retirement	
9	Gender	<b>i. Male</b> <b>ii. Female</b>
10	Type ( <b>please write Pensioner / Family pensioner / Retiree</b> )	
11	Category (Please tick mark)	<ul style="list-style-type: none"> <li>i. SBI retirees on completion of pensionable service in the Bank.</li> <li>ii. Surviving spouses of SBI employee who died whilst in service or after retirement.</li> <li>iii. Existing members of SBI Health care / Policy-A.</li> <li>iv. Old retiree/ surviving spouses / family pensioners of erstwhile Associate Banks of SBI (e-ABs)</li> <li>v. Pensioners removed from service and receiving pension.</li> <li>vi. Pensioners / Retirees who could not join 'SBI Health Assist' in the Policy year 2022-23</li> </ul>
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	Address for communication	<b>Address</b>

		<b>Nearest Landmark</b>										
		<b>Post Office</b>										
		<b>City / District</b>										
		<b>State</b>										
		<b>Pin Code</b>										
15	Landline No. (with STD code)											
16	Mobile No. (it will be used for registration under e-Pharmacy scheme)											
17	Alternate Mobile no. (if any)											
18	Email ID											
19	Name of Spouse (if any)											
20	Date of Birth of Spouse (dd/mm/yyyy)											
21	Name of disabled Child / Children (if any).  (As declared to the Bank)	<b>Sl</b>	<b>Name of the disabled child</b>	<b>Date of Birth (dd/mm/yyyy)</b>	<b>Gender</b>							
		1.										
		2.										
22	Name of the pension/family pension paying branch	<b>Name of the Branch</b>					<b>Branch Code No.</b>					
23	Pension Account No. (11 digit)											
24	IFSC Code											
<b>BASIC COVER PLANS</b>												
25	<b>Sum Insured</b>	<b>Basic Premium</b>	<b>GST @ 18%</b>	<b>Gross Premium (A)</b>	<b>Please Tick Opted Plan</b>							
	<b>3,00,000</b>											

	5,00,000					
<b>ADDITIONAL SUPER TOP-UP COVER**</b>						
26	Base plan	Sum Insured of Additional Super top-up	Basic Premium	GST @ 18%	Gross Premium (B)	Please Tick Opted Plan
	3,00,000	11,00,000				
		16,00,000				
	5,00,000	14,00,000				
		19,00,000				
	<b>CRITICAL ILLNESS COVER **</b>					
27	Sum Insured	Basic Premium	GST @ 18%	Gross Premium (C)	Please Tick if applied	
	5,00,000					
<p><b>** Critical Illness Cover and Additional Super top-up cover will not be available separately and can be taken only with a Base Plan</b></p> <p>** Members should have <b>completed age</b> below 65 years as on 15<sup>th</sup> January 2023 to opt for critical Illness Plan</p> <p><b>N.B. : Pro-rata premium for new retirees will be applicable in all the plans i.e. Basic Cover Plans Additional super top up and Critical Illness Plans.</b></p> <p><b>Employees retiring during currency of the policy should apply by paying the pro-rata premium within 90 days from the date of their of retirement.</b></p>						
28	<b>CALCULATION OF TOTAL PREMIUM (with GST)</b>					
	Premium for Base Plan	Premium for Additional Super top-up Plan (if any)	Premium for Critical Illness (if any)	Total Premium Paid (with GST)		
	(A)	(B)	(C)	A + B + C		

<b>29. Declaration Nominee/s :</b>				
<p>I, Mr./Mrs./Ms. _____, a pensioner of the Bank/ a retired employee / spouse of the deceased employee do hereby assign the money payable by “<b>SBI General Insurance Co. Ltd.</b>” in case of my death to Mr. / Mrs./ Ms. _____  Relation _____ and further declare that his/her receipt shall be sufficient discharge of the company.</p>				
<b>30. Debit Authority for Super Top-up Premium</b>				
<p>I hereby authorize Bank to debit and credit premium of Super Top-up cover of 6 Lacs from my pension account.</p>				
<b>31. Debit Authority:</b>				
<p>I am aware that I along with my spouse and disabled child/children (if any) will be eligible for a health insurance cover under the Family Floater Group Health Insurance ‘Health Assist’. I hereby authorize the Bank to debit the insurance premium amount of Rs. _____ to my pension / family pension account No. _____</p> <p>I undertake to keep sufficient balance in my above account for debiting insurance premium for the policy year 2023-24 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.</p>				
<b>32. Consent-cum- undertaking:</b>				
<p>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.</p> <p>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.</p>				

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'.

**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:

<b>Transaction No. (Journal No.)</b>	<b>Date</b>	<b>:</b>	<b>Amount</b>	<b>:</b>
_____	_____		_____	

**State Bank of India**

**Name of the Forwarding Branch (Code No.) :**

**Place :**

**Date :**

\_\_\_\_\_  
**Signature of the Branch Manager with seal**

*(On Branch Letter head)*

**ACKNOWLEDGEMENT OF PREMIUM PAID**

**(Year 2023-24)**

**'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 & Critical Illness Cover) + Rs. \_\_\_\_\_ (Super Top-up Cover) =**

**\_\_\_\_\_ (in words**

**Rupees \_\_\_\_\_**

**\_\_\_\_\_ ) has been received for enrolment in above Mediclaim Policy.**

**Date \_\_\_\_\_**

**Signature of the Branch official  
issuing the certificate**