ANNEXURE-I

GROUP MEDICLAIM POLICY FOR SBI RETIREES (POLICY-B)

For new members

APPLICATION FORM FOR POLICY-'B' (16.01.2018 – 15.01.2019)

Chief Manager
State Bank of India,
Branch / 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 : 16.01.2018 – 15.01.2019

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	Date of joining the Bank	
04	Date of confirmation in service	
05	Date of Retirement	
06	Retired from	
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.	
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**	
		1 /	dd/mm/yy
		2 /	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 opted for Plan (Please tick the box of Plan chosen) **GST @18%**	**Sl no.**	**Tick here**	**Sum Insured**	**Premium**	**GST @ 18 %**	**Total (Rs.)**
		NON-DOMICILIARY PLANS					
		1		Rs. 3.00 lakhs	16,524	2,974	19,498
		2		Rs. 4.00 lakhs	26,088	4,696	30,784
		3		Rs. 5.00 lakhs	37,175	6,692	43,867
		4		Rs. 7.50 lakhs	73,062	13,151	86,213
		5		Rs. 10.00 lakhs	1,10,996	19,979	1,30,975
		6		Rs. 15.00 lakhs	2,17,790	39,202	2,56,992
		7		Rs. 25.00 lakhs	2,33,055	41,950	2,75,005
		DOMICILIARY PLANS					
		8		Rs. 3.00 lakhs	28,110	5,060	33,170
		9		Rs. 4.00 lakhs	42,480	7,646	50,126
		10		Rs. 5.00 lakhs	59,293	10,673	69,966
		11		Rs. 7.50 lakhs	1,03,099	18,558	1,21,657
		12		Rs. 10.00 lakhs	1,50,702	27,126	1,77,828
		13		Rs. 15.00 lakhs	2,76,084	49,695	3,25,779
		14		Rs. 25.00 lakhs	2,89,275	52,070	3,41,345

Undertaking :

I undertake that I have chosen Plan at serial no._____ above and have agreed to make payment of the corresponding premium of the Plan. I am also aware that the Bank has decided to support the pensioners by allowing subsidy depending upon the Plan chosen. I also know that the amount of subsidy will depend upon the pension drawn by me (Basic + DA). To arrive at the correct amount of subsidy I am attaching my Pension Slip for the month of December 2017 with this application form. I undertake that if any excess amount of subsidy is paid on my behalf, the same may be recovered from my account.

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. _____ to my above account. I undertake to keep sufficient balance in my above account for debiting the insurance premium failing which my policy may not be issued / renewed. I am also aware that Bank may at its sole discretion modify the terms and conditions of the policy from time to time.

Place : **Date :** Pension Slip for the month of ……. attached.	**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 paid the insurance premium as per the following details:	
Amount of Premium as per Plan chosen : Rs. **Less amount of subsidy as per Pension Slip : Rs.** **----------** **Amount paid by the pensioner : Rs.**	
State Bank of India **Name of the Forwarding Branch (Code No.):**	
Place : **Date :**	_____ **Signature of the Branch Manager with seal**

……

ACKNOWLEDGEMENT

(to be given to the applicant by the branch receiving the Form)

Received from Shri/Smt._____

Application for membership of Family Floater Group Mediclaim Policy 'B' along with Insurance Premium including Goods & Services Tax of Rs._____ for onward submission to Admin Office.

Date _____

Branch _____ Stamp of the Branch Signature of the officer receiving the Form