**ANNEXURE-II**

***“SBI Health Assist” Scheme***

**GROUP MEDICLAIM POLICY FOR SBI RETIREES**

**ANNUAL PAYMENT PLAN (APP)**

**CONSENT FOR RENEWAL (2020-21)**

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

The Branch Manager

State Bank of India,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office/ Branch

Dear Sir,

**SUB: Family Floater Group Health Insurance Policy for SBI Retirees, Policy Period: 16.01.2020 –15.01.2021**

|  |  |  |  |
| --- | --- | --- | --- |
| PF No. | | | |
| Name of Pensioner/ Spouse of Deceased 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)  1.  2. | | Gender (M/F) | Dt. of Birth (dd/mm/yyyy) |
| Name of the Nominee | | Relationship of Nominee | |
| Date of Retirement : | |  | |
| Pensioner Type ( Pensioner / Retiree / Family Pensioner) | | | |
| Address of pensioner | | | |
| City |  | | |
| State |  | | |
| Pincode |  | | |
| Mobile No. / Landline No. |  | | |
| Email Id. |  | | |
| Name of Zonal/Administrative office |  | | |
| Name of LHO |  | | |
| Name of Pension Branch |  | | |
| Pension Branch code |  | | |
| Pension Account no. |  | | |
| IFSC code |  | | |
| Date of payment of premium (dd/mm/yyyy) |  | | |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sum Insured (Rs in Lakhs)** | **Premium details for Basic Cover (Without Domiciliary)** | | | |
| **Basic Premium** | **GST @ 18%** | **Gross Premium (A)** | **Please Tick Opted Plan** |
| **3,00,000** |  |  |  |  |
| **5,00,000** |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sum Insured** | **Basic Premium** | **GST @ 18%** | **Gross Premium (B)** | **Please Tick Opted Plan** |
| **5,00,000\*\*** |  |  |  |  |
| **\*\*Critical Illness Cover will not be available separately and can be taken only with a base plan.** | | | | |

**Calculation of Total Premium :**

|  |  |  |
| --- | --- | --- |
| **Premium for Basic Plan Opted**  **with GST**  **(A)** | **Critical Illness Plan Premium**  **(If any) with GST**  **(B)** | **Total Premium (with GST)**  **A+B = C** |
|  |  |  |

**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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 / Savings Bank Account No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Date : Signature of Retired Employee/ Spouse**

**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