**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)<br>1.<br>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