ANNEXURE-III

"SBI HEALTH ASSIST" SCHEME (2023-24)

CONSENT FOR RENEWAL

Date of payment of premium	
Journal No.	
Amount paid	

The Branch Manager
State Bank of India,
_____ **Branch/THIRUVANANTHAPURAM AO**

Dear Sir,

SUB: Family Floater Group Health Insurance Policy 'B' for SBI Retirees,
Policy Period: 16.01.2023 –15.01.2024

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) 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	THIRUVANANTHAPURAM AO
Name of LHO	THIRUVANANTHAPURAM

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 Lakhs)	**Premium details for Basic Cover**			
	Basic Premium (Amt. in Rs.)	**GST @ 18%** (Amt. in Rs.)	**Gross Premium (Rounded off) (A)** (Amt. in Rs.)	**Please Tick Opted Plan**
3.00	16,517	2,973.08	19,490	
5.00	36,716	6,608.82	43,325	

Premium details for Additional Super Top cover					
Base plan (Amt. in lakhs)	**Additional Super Top-up** (Amt. in lakhs)	**Basic premium** (Amt. in Rs.)	**GST@18%** (Amt. in Rs.)	**Gross Premium (Rounded off) (B)** (Amt. in Rs.)	**Please Tick Opted Plan**
3.00	**11.00**	5,015	902.78	5,918	
	16.00	6,220	1,119.53	7,339	
5.00	**14.00**	9,516	1,712.82	11,228	
	19.00	10,876	1,957.61	12,833	

Sum Insured	**Basic Premium** (Amt. in Rs.)	**GST @ 18%** (Amt. in Rs.)	**Gross Premium (Rounded off) (C)** (Amt. in Rs.)	**Please Tick Opted Plan**
5,00,000**	13,753	2,475.59	16,229	
****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)	**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**

Consent-cum- undertaking:

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'.

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 'B'. I hereby authorize the Bank to debit the insurance premium amount of Rs. _____to my pension / family pension account / Savings Bank Account No. _____.AND

CREDIT THE AMOUNT TO SBI HEALTH INSURANCE POLICY THIRUVANANTHAPURAM AO

ACCOUNT No 35465086912

Debit Authority for Super Top-up Premium

I hereby authorize Bank to debit and re-credit the premium for Super Top-up cover of 6 Lacs from my pension account.

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

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._____ (in
word
Rupees _____)
has been received for enrollment in above Mediclaim Policy.

Date _____

Stamp of the Branch

Signature of the officer receiving the Form