

“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