ANNEXURE-V

"SBI HEALTH ASSIST" SCHEME

GROUP MEDICLAIM POLICY 'B' FOR SBI RETIREES

APPLICATION FORM FOR NEW MEMBERS

Policy 'B' (16.01.2025 – 15.01.2026)

Date of payment of premium	
Journal No.	
Amount paid	

Affix coloured joint photograph of the member and spouse

Chief Manager
State Bank of India,
Branch / Administrative office,

_____

Dear Sir,

SUB: SBI Health Assist Group Health Insurance Policy for SBI Retirees
Policy Period: 16.01.2025 – 15.01.2026

I am interested in joining the Family Floater Group Health Insurance Policy of State Bank of India (Policy B – SBI Health Assist Scheme) and furnish the required information as under:

Sl.	Particulars	Remarks
1 A	P.F Index No./ HRMS ID	
1 B	PF ID (for pre-merger retirees of e-Abs who don't have **HRMS ID**) for example **" SBM1234/ SBH1234, SBP1234……."**	
2	Name of retiree / Family pensioner	
3	Date of Birth of retiree / Family pensioner	dd/mm/yyyy
4	Date of joining the Bank	
5	Date of Retirement	

6	Date of Death of deceased employee/ pensioner (applicable for Family pensioners)		
7	Retired as **Clerical/Sub-staff/JMGS-I/MMGS-II/MMGS-III/SMGS-IV/SMGS-V/TEGS-VI/TEGS-VII/TEGSS-I/TEGSS-II**		
8	Age (in years) as on the date of retirement		
9	Gender	**i. Male** **ii. Female**	
10	Type **(please write Pensioner / Family pensioner / Retiree)**		
11	Category (Please tick mark)	i. SBI retirees on completion of pensionable service in the Bank. ii. Surviving spouses of SBI employee who died whilst in service or after retirement. iii. Existing members of SBI Health care / Policy-A. iv. Old retiree/ surviving spouses / family pensioners of erstwhile Associate Banks of SBI (e-ABs) v. Pensioners removed from service and receiving pension. vi. Pensioners / Retirees who could not join 'SBI Health Assist' in the Policy year 2024-25	
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	Address for communication	**Address**	
		Nearest Landmark	
		Post Office	
		City / District	

		State	
		Pin Code	
15	Landline No. (with STD code)		
16	Mobile No. (**it will be used for registration under e-Pharmacy scheme**)		
17	Alternate Mobile no. (mandatory)		
18	Email ID (mandatory)		
19	Name of Spouse (if any)		
20	Date of Birth of Spouse (dd/mm/yyyy)		

21	Name of disabled Child / Children (if any) (As declared to the Bank)	**Sl**	**Name of the disabled child**	**Date of Birth** (dd/mm/yyyy)	**Gender**
		1.			
		2.			

22	Name of the pension/family pension paying branch	**Name of the Branch**	**Branch Code No.**

23	Pension Account No. (11 digit)											
24	IFSC Code											

BASIC COVER PLANS

25	**Sum Insured**	**Basic Premium**	**GST @ 18%**	**Gross Premium (A)**	**Please Tick Opted Plan**
	3,00,000	18,210.00	3,277.80	21,488.00	
	5,00,000	40,480.00	7,286.40	47,766.00	

ADDITIONAL SUPER TOP-UP COVER**

26	**Base plan**	**Sum Insured of Additional Super top-up**	**Basic Premium**	**GST @ 18%**	**Gross Premium (B)**	**Please Tick Opted Plan**
	3,00,000	**11,00,000**	5,529.00	995.22	6,524.00	
		16,00,000	6,858.00	1,234.44	8,092.00	

		21,00,000	9,001.00	1,620.18	10,621.00	
	5,00,000	**14,00,000**	10,492.00	1,888.56	12,381.00	
		19,00,000	11,991.00	2,158.38	14,149.00	
		29,00,000	18,303.00	3,294.54	21,598.00	
		39,00,000	24,613.00	4,430.34	29,043.00	

CRITICAL ILLNESS COVER **

27	**Sum Insured**	**Basic Premium**	**GST @ 18%**	**Gross Premium (C)**	**Please Tick if applied**
	5,00,000	15,163.00	2,729.34	17,892.00	

**** Critical Illness Cover and Additional Super top-up cover will not be available separately and can be taken only with a Base Plan**

****Members should have completed age below 65 years as on 15th January 2025 to opt for Critical illness Plan**

N.B. : Pro-rata premium for new retirees will be applicable in all the plans i.e. Basic Cover Plans, Additional super top up and Critical Illness Plans.

Employees retiring during currency of the policy should apply by paying the pro-rata premium within 90 days from the date of their retirement.

28	**CALCULATION OF TOTAL PREMIUM (with GST)**			
	Premium for Base Plan	**Premium for Additional Super top-up Plan (if any)**	**Premium for Critical Illness (if any)**	**Total Premium Paid (with GST)**
	(A)	**(B)**	**(C)**	**A + B + C**

29 **The information regarding all four vendors is uploaded on https://sbi.co.in/web/personal-banking/pension-seva . Kindly go through the document containing the services offered by each vendor and then select a vendor of your preference.**

Selection of e-Pharmacy Vendor (Anyone) –

1. Medibuddy
2. Tata 1MG
3. Urlife

I hereby select vendor M/S_____ as my e-Pharmacy vendor for providing services during Policy year 2025-26. To enable the vendor so selected to allow access to the services offered by them, I authorize the Bank to

	share my PF ID/ contact details and details of my/ my family members to such vendor, for which I give my consent herewith.

30. Declaration Nominee/s :

I, Mr./Mrs./Ms. _____ , a pensioner of the Bank/ a retired employee / spouse of the deceased employee do hereby assign the money payable by **"SBI General 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.

31. Debit Authority for Super Top-up Premium

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

32. Debit Authority:

I am aware that I along with my spouse and disabled child/children (if any, as declared to Bank) will be eligible for a health insurance cover under the Family Floater Group Health Insurance 'Health Assist'. I hereby authorize the Bank to debit the insurance premium amount of Rs. _____ to my pension / family pension account No. _____.

I undertake to keep sufficient balance in my above account for debiting insurance premium for the policy year 2025-26 failing which the policy may not be issued to me. I am also aware that Bank may at its sole discretion can modify the terms and conditions of the policy from time to time.

33. 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'.	
Place : **Date :**	**Signature of Retired Employee / Spouse**

For office use only

Certified that Shri / Smt. _____ is a retired employee / spouse of the retired / deceased employee of SBI / e-ABs and he / she has remitted the insurance premium as per the following details:

Transaction No. (Journal No.) _____	**Date :** _____	**Amount :** _____
State Bank of India **Name of the Forwarding Branch (Code No.):**		
Place: **Date :**	**Signature of the Branch Manager with seal**	

ACKNOLEGEMENT OF PREMIUM PAID

Name of the applicant –
PF ID number --
Base plan –
Additional Super Top-up Plan (if applied) --
Critical illness Plan (if applied)--

Premium paid --
Date of Transaction –

_____

Signature of the Branch Manager with seal

(On Branch Letter head)

ACKNOWLEDGEMENT OF PREMIUM PAID

(Year 2025-26)

'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_____

(Base Plan/ Additional Super Top-up / Critical Illness Cover) + (Super Top-up Cover of 6 lacs) Full Year Pro-rata Premium is 8,613 = _____

(In words Rupees_____

_____) has been received for enrolment in above Mediclaim Policy.

Date_____

Signature of the Branch official issuing the certificate