

AROGYA SUPREME

POLICY SCHEDULE

Policy No:	Servicing Branch Office:	Issue Date:
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INTERMEDIARY DETAILS

Intermediary Name	xxxxxxxxxx	Intermediary Code	xxxxxxxxxx
Contact Details	Mobile No. - xxxxxxxxxx	Landline No.	xxxxxxxxxx
Address			

PROPOSER DETAILS

Name of Proposer			
Present Address (Current Residing Address)	Village: _____ Gram Panchayat: _____ City: _____ State: _____ Pin-code: _____ Landmark: _____ Zone: _____		
Permanent Address	Village: _____ Gram Panchayat: _____ City: _____ State: _____ Pin-code: _____ Landmark: _____ Zone: _____		
PAN No / Form 60/61.			
GSTN No			
Email			
Contact Details			
Period of Insurance	From Date and Time: DD / MM / YYYYhrs	To Date and Time: DD / MM / YYYY midnight	
First Policy Inception Date	DD / MM / YYYY		
Business Type	New/ Renewal/ Migration/ Portability		
Previous Policy Number	XXXXXXXXXX		
Policy Type	Individual / Family Floater		
Plan Name	PRO / PLUS / PREMIUM		
Premium Frequency	Monthly / Quarterly / Half yearly /Single		
No of Members:			

As part of our Go Green initiative, your policy will be issued digitally to your registered mobile number via WhatsApp, SMS, and email. By issuing an e-policy, we help conserve the environment by saving a tree. An electronic policy document holds the same legal validity as a physical copy. The date on which the policy document is delivered will be considered for determining the free look period.

However, if you would prefer to receive a physical copy of your policy document, simply send an SMS with the message "PRINT <Policy Number>" to 561612 from your registered mobile number.

INSURED PERSON'S DETAILS

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of the Insured						
Date of Birth						
Age						
Gender						
Height						
Weight						
Occupation						
Nationality (Indian/ Non-Indian/ Non-resident Indian/ Other)						
Marital Status						
Relationship with Proposer						
Basic Sum Insured						
Cumulative Bonus / Enhanced Cumulative Bonus (if opted)						
Pre-existing Disease/s* Disability Details (if any)	Yes/No, If yes provide details					
ABHA (Ayushman Bharat Health Account) number (if available) [#]						

WAITING PERIOD

Name of Insured Person	First 30 Days	Specified Diseases and Procedures	Pre-Existing Diseases	Cataract	COVID -19

Note:

- If any of the specified disease / procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- First 30 days waiting period shall not be applicable for claims arising due to COVID-19, Major Illness-Benefit, Hypertension, Diabetes and Cardiac Condition.

NOMINEE DETAILS

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of the Nominee						
Date of Birth (DD/MM/YYYY)						
Age						
Gender (M/F/O)						
Relationship with Policyholder						

Mobile No. of the Nominee					
Present Address of the Nominee					
Permanent Address of the Nominee					
Nominee Email ID					

APPOINTEE DETAILS

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name of Appointee						
Date Of Birth (DD/MM/YYYY)						
Age:						
Gender (M/F/O)						
Relationship with Nominee						
Address of the Appointee						
Appointee Mobile No						

SPECIAL CONDITION

Coverage Subject to additional condition, deductible, co-pay as below

1.	
2.	

IMPORTANT TERMS, CONDITIONS AND EXCLUSION

1.	
2.	

Name of Insured Person	Pre-existing disease/Disability/ hospitalization/ medical treatment /surgical history	Permanent disease exclusion if any

ADDITIONAL LOADING (if applicable)

Name of Insured Person	Habit	Disease

PREMIUM DETAILS:

Particulars	Amount (₹)
Premium in Rs.	
Optional Cover Premium in Rs.	
Loading (if any) in Rs.	
Discount (if any) in Rs.	
Instalment Loading (if any) in Rs.	
Total Premium with Instalment Loading	
EMI amount (as per Instalment frequency opted)	
Add Taxes as applicable	
Final Premium (EMI Amount with Taxes) in Rs.	

Disclaimer: Final amount payable will include tax as applicable.

Collection Details:

Receipt no:

Receipt Date:

Signed at: (RO/BO/DO – Details)		For SBI General Insurance Company Limited
Date		Authorized Signatory

P.S. If premium paid through cheque, the policy is void ab initio in case of dishonour of cheque.

Consolidated Stamp Duty paid towards Insurance Policy Stamps vide Order No _____ Dated _____ of General Stamp Office, Mumbai

GSTIN: _____

CONTACT DETAILS IN CASE OF ANY CLAIM

Email	sbig.health@sbigeneral.in
Toll Free number	1800 102 1111 (Available 24/7) For agents and intermediaries 1800 22 1111 (Available 24/7)
Website	www.sbigeneral.in
Fax No	1800227244, 18001027244

GRIEVANCE REDRESSAL PROCEDURE

Stage 1:

If you are dissatisfied with the resolution provided above or for lack of response, you may write to head.customercare@sbigeneral.in We will look into the matter and decide the same expeditiously within 14 days from the date of receipt of your complaint.

For Senior Citizens: Senior Citizens can reach us at seniorcitizengrievances@sbigeneral.in; Toll Free - 1800 102 1111 (Available 24/7)

Stage 2:

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may send your Appeal addressed to the Grievance Redressal Officer at: gro@sbigeneral.in or contact at 022-45138021.

Address: Grievance Redressal Officer, 9th Floor, A & B Wing, Fulcrum Building, Sahar Road, Andheri (East), Mumbai 400 099.
List of Grievance Redressal Officers at Branch:

<https://content.sbigeneral.in/uploads/0449cac1bcd144bbb160d3f6b714fbcd.pdf/>

Stage 3:

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may Register your complaint with IRDAI on the below given link

<https://bimabharosa.irdai.gov.in/Home/Home>

Stage 4:

If your grievance remains unresolved from the date of filing your first complaint or is partially resolved, you may approach the Insurance Ombudsman falling in your jurisdiction for Redressal of your Grievance. The details of the Insurance Ombudsman can be accessed at (<https://www.cioins.co.in/Ombudsman>)

IMPORTANT NOTE

Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all information related to his health and which has a bearing on the acceptance or rejection of the Proposal by the Insurer and also not to suppress any factual information in response to the questions in the proposal form.

Please examine this Policy including its attached Schedules/ Annexure if any. In the event of any discrepancy, contact the office of the Insurer immediately, it being noted that this Policy shall be otherwise considered as being entirely in order.

In case of payment by cheque, in the event of dishonour of cheque for any reason whatsoever, insurance provided under this document automatically stands cancelled from the inception of the Policy irrespective of whether a separate communication is sent or not.

Any claim arising or related to consequences of the Pre-existing diseases as defined under the Policy is excluded from the scope of Policy cover unless the insurer specifically accepts the pre-existing disease declared with or without additional premium and coverage terms specifically mentioned in the schedule. The Policy shall become voidable at the option of Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particulars declared by the Policy Holder in the Proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Policy Holder or anyone acting on his behalf.

To verify your Policy details click/ visit www.sbigeneral.in

All terms, conditions and exclusions as per standard Policy wordings attached with this schedule.

Signed at (RO/BO/DO – Details)		For SBI General Insurance Company Limited
Date and Place		Authorised Signatory

COVERAGE DETAILS

Name of Insured Person	SR No	Hospitalization Cover	Plan Name: PREMIUM
			Sum Insured / Sub limits
a. b. c. d. e. f.		Sum Insured	25,00,000
	1	In-patient Hospitalization Treatment	Up to Sum Insured
	2	Mental Healthcare	Upto Sum Insured
	3	HIV / AIDS Cover	Upto Sum Insured
	4	Genetic Disorder	Maximum of ₹1,00,000/-
	5	Internal Congenital Anomaly	25% of Base Sum Insured
	6	Bariatric Surgery Cover	Upto Sum Insured
	7	Advance Procedures	25% of Base Sum Insured
	8	Cataract Treatment	₹1,00,000/- per eye

9	Pre-Hospitalization Cover	60
10	Post-Hospitalization Cover	180
11	Domiciliary Hospitalization	Up to Sum Insured
12	Day Care Treatment	Up to Sum Insured
13	Road Ambulance (per hospitalization)	₹ 7,000/-
14	Organ Door Expenses	Up to Sum Insured
15	Alternative Treatment / AYUSH	Up to Sum Insured
16	Recovery / Convalescence Benefit (per hospitalization), if hospitalization is above 10 days	₹15,000/-
17	Domestic Emergency Assistance (including Air Ambulance)	Upto ₹10,00,000/-
18	Sum Insured Refill	100% of Sum Insured
19	Compassionate Visit (air ticket charges if hospitalization is exceeding 5 days)	1% of Sum Insured maximum up to 20,000/-
20	E-Opinion	<<Yes/No>> <<Yes>> Unlimited

OPTIONAL COVERS

Name of Insured Person	Hospital Cash Benefit	*Major Illness Benefit	Additional Sum Insured for Accidental Hospitalization	Enhanced Cumulative Bonus	NCB Protector	Co-Payment	Deductible
Sum Insured/ Sub Limit							
a	<<no of days 15>> ₹1000/- (normal hospitalization) ₹2000/- (ICU hospitalization)	100% of Sum Insured maximum up to ₹25,00,000/-	1.5X of the Basic Sum Insured	50% of Sum Insured	If claim is less than ₹50,000/- We will protect NCB% at the time of Renewal of Policy with Us	10%	₹10,000/- (applicable on each and every claim)
b	<<no of days 15>> ₹1000/- (normal hospitalization) ₹2000/- (ICU hospitalization)	100% of Sum Insured maximum up to ₹25,00,000/-	1.5X of the Basic Sum Insured	50% of Sum Insured	If claim is less than ₹50,000/- We will protect NCB% at the time of Renewal of Policy with Us	10%	₹10,000/- (applicable on each and every claim)

Note: Major Illness is applicable only if the Insured Person who is aged above 18 years

RENEWAL BENEFIT

Preventive Health Check-Up	Haematology: CBC + ESR + Haemoglobin + PS Diabetes Profile: Fasting Blood Sugar + HbA1c Lipid Profile: Total Cholesterol + HDL Cholesterol + LDL Cholesterol + Triglycerides Liver Function Tests: SGOT + SGPT + Bilirubin Total Kidney / Renal Function: Bun and Creatinine + Uric Acid Thyroid Profile: T3+ T4+ TSH Urine Analysis: Urine Complete Analysis Iron Deficiency: Iron Profile
Cumulative Bonus	10% of Sum Insured

PREMIUM CERTIFICATE (Applicable to all sections except Personal Accident)

Premium certificate for the purpose of deduction under section 80 - (D) of Income Tax (Amendment) Act, 1986

Transaction Id:

This is to certify that Mr./Ms./Mrs. ----- has paid INR-----
(In Words-----) towards the premium for Health Insurance vide Direct Credit Transaction ID/Cheque No. xxxxxxxxx for the period from ---(dd/mm/yy)----- To ----- (dd/mm/yy) ----- Midnight for Policy No. xxxxxxxxx

Upon issuance of this receipt, all previously issued temporary receipts, if any, related to this policy are considered null and void. For the purpose of deduction under section 80D. The benefit shall be as per the provisions of the Income Tax Act, 1961 and any amendments made thereafter.

You may get tax benefits up to ' _____' subject to maximum permissible limits under Income Tax Act 1961 as modified from time to time. For more details kindly consult your tax advisor. In the event of non-realization of premium, benefits cannot be obtained against this premium receipt.

GSTI No.: _____

Date: DD/MM/YYYY

Place:

Authorised Signatory

GST TAX INVOICE

GST Invoice No:	XXXX	GST Invoice Date	DD/MM/YYYY
GSTIN/Unique No: (SBI General)	27AAMCS8857L1ZC	SBI General State	Maharashtra
SBI General Branch Address:	SBI General Insurance Company Limited Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai - 400 099.		

DETAILS OF POLICYHOLDER										
Name										
Address										
Policy Holder State					Place of Supply					
					Whether invoice under Reverse Charge		No			
GSTIN/Unique No:		XXXXXXXX			Policy Number		XXXXXXXX			
Insurance Product Name	HSN Code	Premium (without Taxes)	CGST		SGST/ UTGST		IGST			
			Rate	Amount	Rate	Amount	Rate	Amount		
Total Invoice Value (In Figures)										
Taxes Applicable									Authorised Signatory	
SBI General Receipt No:							Receipt Date:	DD/MM/YYYY		

RECEIPT

Received with thanks from XXXXXXXXXXXXXXXXX

an amount of ₹ XXXXXX (In Word - XXXXX)

by EFT

No: XXXXXXXX

Dated: DD/MM/YYYY

Drawn on Bank: STATE BANK OF INDIA Branch:

Party ID	Quote/Policy/Claim No.	Name of Party	Amount (₹)
XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX
		TOTAL	XXXXXXX

Disclaimer

1. Receipt subject to realization of instrument submitted
2. Kindly refer to the policy document for the time of commencement of cover

For and on behalf of
SBI General Insurance Co. Ltd.

Authorized Signatory