Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, with Domiciliary Treatment coverage

Fror		То	
Sri /	i / Smt	The Manager / Sr Manager	
Staf	aff No	HRM Section	
MOD	ob No: mail id:	Circle Office,	
em	mait id.		
Pres	esently covered under		
Don	omiciliary Non Domiciliary		
Dies	ages tick the appropriate box		
Plea	ease tick the appropriate box		
	n case the renewal option is from spouse of on case to be mentioned here:		No. of ex-
Doc	osidontial Address.		
res	esidential Address:		
1.		ontents of HO Circular 494/2019 dated 26 2019 dated 07.11.2019 issued by Can	
2.	I am consenting to renew the IBA Gr Treatment coverage subject to paymen	roup Medical Insurance Policy, <u>with Do</u> nt of agreed Insurance Premium by me.	<u>omiciliary</u>
3.	amount under the scheme or admini	Bank is in no way responsible for payme istration of policy and Bank is only for andate executed by me and it shall be n and in time.	acilitating
4.	case of Officer or Rs 61,784/- in case of in case of revision as informed by the indicated earlier to pay the premium no	annual premium amount (presently Rs 8) of workmen) or such other higher premium insurance company from my account a low and in future also. I will ensure that fully understand that in case sufficient policy would be treated as lapsed.	m amount as already sufficient
5. Date:	to renew/join the IBA Group Healt before 31/10/2019 due to some unavoid Group Health Insurance for Retirees for agree that the period of coverage sharemittance of full premium.	e), Staff No could not submit the Insurance for Retirees for 2019-20 dable reasons. I hereby opt to join/renewor 2019-20 and remit the full premium. all be from 01/12/2019 to 31/10/2020 s	20 on or w the IBA I further

[Signature]

Super Top up Policy without OPD (Domiciliary) Cover

- 1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".
- 2. I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs 6,134/- in case of Officer or Rs 5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date:

The additional details to be provided by such spouses of the deceased ex-employees who expired between 01.11.2018 to 31.10.2019

Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, with Domiciliary Treatment coverage

Name of the Spouse:		
Residential Address:		
Name of the spouse	:	
DOB of the spouse	•	
Name & Staff No. deceased employee/	retiree:	
Date of Birth of the Deceased Employe	e:	
Designation at the time of Retirement	death :	
Date of Retirement /Death	:	
Branch/office last worked	:	
Circle office	:	
Mode of Exit	:	
Family Pension paying Account No	:	
Operative Canara Bank SB Account i	n case on Non-	
Pensioners	:	
Branch Name	:	
DP Code	:	
IFSC No.	:	
PAN NO of spouse	:	
Contact Telephone No.	:	
Mobile No	<u>:</u>	
Contact Email ID of spouse or relative:		
511/2019 dated 04.10.2019 & 565/ the renewal premium rates.	2019 dated 07.	HO Circular 494/2019 dated 26.09.2019, 11.2019 issued by Canara Bank conveying opted for IBA Group Medical Group Insurance
	Insurance Policy,	with Domiciliary Treatment coverage, subject
also understand and accept that the E he scheme or administration of policy	Bank is in no way	responsible for payment of any amount under $\ensuremath{\emph{\prime}}$ facilitating remittance of premium based on
or Rs 61,784/- in case of workmen) of informed by the insurance company from and in future also. I will ensure	or such other his om my account as that sufficient b	nount (presently Rs 82,373/- in case of Officer gher premium amount in case of revision as already indicated earlier to pay the premium balance is maintained in the account. I fully ained my option / renewal of policy would be
,Spouse of (Name renew/join the IBA Group Health Insur some unavoidable reasons. I hereby opt	cance for Retiree t to join/renew t m. I further ag	ff No could not submit the option to s for 2019-20 on or before 31/10/2019 due to he IBA Group Health Insurance for Retirees for ree that the period of coverage shall be full premium.
e:		FC:
		[Signature]
Super Ton	un Policy withou	t (Domiciliary)

Super Top up Policy without (Domiciliary)

1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".

2. I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs 6,134/- in case of Officer or Rs 5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date:

1.

2.

3.

4.

5.

6.

Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, <u>Without Domiciliary Treatment coverage</u>

		То
Sri		The Manager / Sr Manager
Sta		HRM Section
Mo	Mob No:	Circle Office,
e n	e mail id:	
Pre	Presently covered under	
	Domiciliary Non Domiciliary	
Ple	Please tick the appropriate box	
•	(In case the renewal option is from spouse of decease employee to be mentioned here:	• •
Res	Residential Address:	
	I have read and fully understood the contents of 511/2019 dated 04.10.2019 & 565/2019 dated 0 the renewal premium rates.	
	I am consenting to renew the IBA Group Medic <u>Treatment coverage</u> , subject to payment of agr	
3.	I also understand and accept that the Bank is amount under the scheme or administration remittance of premium based on the mandate e ensure that renewal premium is remitted in time	of policy and Bank is only facilitating executed by me and it shall be my duty to
4.	I authorize Canara Bank to debit the annual processe of Officer or Rs 24,897/- in case of working in case of revision as informed by the insurary indicated earlier to pay the premium now and balance is maintained in the account. I fully unnot maintained my option / renewal of policy working.	nen) or such other higher premium amount ace company from my account as already in future also. I will ensure that sufficient aderstand that in case sufficient balance is
5.	I,	nce for Retirees for 2019-20 on or asons. I hereby opt to join/renew the IBA 20 and remit the full premium. I further
Date	ate:	[Signature]

Super Top up Policy without (Domiciliary)

- 1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".
- I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs 6,134/- in case of Officer or Rs 5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date:

The additional details to be provided by such spouses of the deceased ex-employees who expired between 01.11.2018 to 31.10.2019

Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, without Domiciliary Treatment coverage

Name of the deceased retired employee & Staff no :					
Residential Address:					
Name of the spouse :					
DOB of the Spouse :					
Name & Staff No. deceased employee/ retiree:					
Date of Birth of the Deceased Employee :					
Designation at the time of Retirement/death :					
Date of Retirement / Death :					
Branch/office last worked :					
Circle office :					
Mode of Exit :					
Family Pension paying Account No :					
Operative Canara Bank SB Account in case on Non-Pensioners :					
Branch Name :					
DP Code :					
IFSC No. :					
PAN NO of spouse :					
Contact Telephone No. :					
Mobile No :					
Contact Email ID of spouse or relative:					
I have read and fully understood the contents of HO C dated 04.10.2019 & 565/2019 dated 07.11.2019 issued brates. Last year my spouse Sri / Smt(), had	y Canara Bank conveying the renewal premium				
Policy & he/she has expired on					
I am willing to renew the said Medical Insurance Pol					
subject to payment of agreed Insurance Premium by me. I also understand and accept that the Bank is in no way					
the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me.					
	nount (presently Rs 33 193/- in case of Officer				
I authorize Canara Bank to debit the annual premium amount (presently Rs. 33,193/- in case of Office or Rs.24,897/- in case of workmen) or such other higher premium amount in case of revision as					
informed by the insurance company from my account as already indicated earlier to pay the premium					
	now and in future also. I will ensure that sufficient balance is maintained in the account. I fully				
understand that in case sufficient balance is not maintain					
treated as lapsed.	, , ,				
I,	Staff No could not submit the option				
to renew/join the IBA Group Health Insurance for Retire					
some unavoidable reasons. I hereby opt to join/renew t					

Date:

1.

2.

3.

4.

5.

6.

Name of the Spouse:

[Signature]

Super Top up Policy without (Domiciliary)

2019-20 and remit the full premium. I further agree that the period of coverage shall be

1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".

from 01/12/2019 to 31/10/2020 subject to remittance of full premium.

2. I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs.6,134/- in case of Officer or Rs.5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date:

Willingness/Consent/Authorisation letter to join in the IBA Group Medical Insurance Policy, without Domiciliary Treatment coverage.

(Ex-Employees those who had not opted for pro rata premium those who retired between from 01.10.2018 to 30.09.2019)

From Sri / Smt Staff No Mob No: e mail id:		To The Manager / Sr Manager HRM Section Circle Office,
Residential Address:		
Name & Staff No	:	
Designation at the time of Retireme	nt :	
Date of Retirement	:	
Branch/office last worked	:	
Circle office	:	
Mode of Exit	:	
Pension paying Account No	:	
Operative Canara Bank SB Account	in case on	
Non-Pensioners	:	
Branch Name	:	
DP Code	:	
IFSC No.	:	
PAN NO	:	
Contact Telephone No.	:	
Mobile No	:	
Contact Email ID of self or	spouse or	
relative	:	
The detailed information of myself a using black ink. Affix the signature be	•	e as under: [Please furnish in capital letters ograph.]

Sl. No	Full Name of Self & Staff No / Name of Dependent Spouse.	Date of Birth (DD/MM/YYYY)	Gender	Relationship	Photograph
	Self				Self Signature
	Spouse				Spouse Signature

- 1. I have read and fully understood the contents of HO Circular 494/2019 dated 26.09.2019, 511/2019 dated 04.10.2019 & 565/2019 dated 07.11.2019 issued by Canara Bank conveying the renewal premium rates.
- 2. I am consenting to opt for the IBA Group Medical Insurance Policy, <u>Without Domiciliary Treatment coverage</u>, subject to payment of agreed Insurance Premium by me.
- 3. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me and it shall be my duty to ensure that renewal premium is remitted in time.
- 4. I authorize Canara Bank to debit the annual premium amount (presently Rs 33,193/-in case of Officer or Rs 24,897/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account as already indicated earlier to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.

Date:

[Signature]

Super Top up Policy without (Domiciliary)

- 1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".
- 2. I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs 6,134/- in case of Officer or Rs 5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date:

7

Annexure 4

Willingness/Consent/Authorisation letter to join in the IBA Group Medical Insurance Policy, without Domiciliary Treatment coverage.

(Spouses of Ex-Employees who had deceased between from 01.10.2018 to 30.09.2019 and not opted for pro rata premium)

Name of the Spouse:	10:
Residential Address:	
Name of the spouse :	
DOB of the Spouse :	
Name & Staff No. deceased employee/ retire	ee:
Date of Birth of the Deceased Employee :	
Designation at the time of Retirement/death	h :
Date of Retirement /death	:
Branch/office last worked	:
Circle office	:
Mode of Exit	:
Family Pension paying Account No	:
Operative Canara Bank SB Account in cas	se on
Non-Pensioners	:
Branch Name	:
DP Code	:
IFSC No.	:
PAN NO of spouse	:
Contact Telephone No. :	
Mobile No :	
Contact Email ID of spouse	or
relative :	

The detailed information of myself is as under: [Please furnish in capital letters using black ink. Affix the signature below the Photograph.]

Sl. No	Full Name of Spouse & Staff No of the ex employee	Date of Birth (DD/MM/YYYY) Of Spouse	Gender	Relationship	Photograph
	Spouse				Spouse Signature

- 1. I have read and fully understood the contents of HO Circular 494/2019 dated 26.09.2019, 511/2019 dated 04.10.2019 & 565/2019 dated 07.11.2019 issued by Canara Bank conveying the renewal premium rates.
- 2. I am willing to opt for Medical Insurance Policy, <u>without Domiciliary Treatment coverage</u>, subject to payment of agreed Insurance Premium by me.
- 3. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me.
- 4. I authorize Canara Bank to debit the annual premium amount (presently Rs 33,193/- in case of Officer or Rs 24,897/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account as already indicated earlier to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.
- 5. I,Spouse of (Name of Retiree), Staff No. could not submit the option to renew/join the IBA Group Health Insurance for Retirees for 2019-20 on or before 31/10/2019 due to some unavoidable reasons. I hereby opt to join/renew the IBA Group Health Insurance for Retirees for 2019-20 and remit the full premium. I further agree that the period of coverage shall be from 01/12/2019 to 31/10/2020 subject to remittance of full premium.

n .	
I Iato	•
vale	•

[Signature]

Super Top up Policy without (Domiciliary)

- 1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".
- 2. I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs 6,134/- in case of Officer or Rs 5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date:

Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, with Domiciliary Treatment coverage

(Ex-Employees those who had not opted for pro rata premium those who retired between from 01.10.2018 to 30.09.2019)

From Sri / Smt Staff No	To The Manager / Sr Manager HRM Section
Mob No:e-mail id:	Circle Office,
Residential Address:	
Name & Staff No :	
Designation at the time of Retirement :	
Date of Retirement :	
Branch/office last worked :	
Circle office :	
Mode of Exit :	
Pension paying Account No :	
Operative Canara Bank SB Account in case on	
Non-Pensioners :	
Branch Name :	
DP Code :	
IFSC No. :	
PAN NO :	
Contact Telephone No. :	
Mobile No :	
Contact Email ID of self or spouse or	
relative :	
The detailed information of myself and spouse ar using black ink. Affix the signature below the Photosical Edit Name of Solf & Date of Birth	ograph.]

Sl. No	Full Name of Self & Staff No / Name of Dependent Spouse.	Date of Birth (DD/MM/YYYY)	Gender	Relationship	Photograph
	Self				Self
					Signature
	Spouse				Spouse
					Signature

- 1. I have read and fully understood the contents of HO Circular 494/2019 dated 26.09.2019, 511/2019 dated 04.10.2019 & 565/2019 dated 07.11.2019 issued by Canara Bank conveying the renewal premium rates.
- 2. I am consenting to opt for IBA Group Medical Insurance Policy, <u>with Domiciliary</u> <u>Treatment coverage</u> subject to payment of agreed Insurance Premium by me.
- 3. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me and it shall be my duty to ensure that renewal premium is remitted in time.
- 4. I authorize Canara Bank to debit the annual premium amount (presently Rs 82,373/- in case of Officer or Rs 61,784/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account as already indicated earlier to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.

Date:

[Signature]

Super Top up Policy without OPD (Domiciliary) Cover

- 1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".
- 2. I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs 6,134/- in case of Officer or Rs 5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date:

Willingness/Consent/Authorisation letter to continue in the IBA Group Medical Insurance Policy, with Domiciliary Treatment coverage

(Spouses of Ex Employees who had deceased between from 01.10.2018 to 30.09.2019 and not opted for pro rata premium)

Name of the Spouse:	
Residential Address:	
Name of the spouse :	
DOB of the spouse :	
Name & Staff No. deceased employee/ retiree	:
Date of Birth of the Deceased Employee:	
Designation at the time of Retirement/death	:
Date of Retirement /death	:
Branch/office last worked	:
Circle office	:
Mode of Exit	:
Family Pension paying Account No	:
Operative Canara Bank SB Account in case	on
Non-Pensioners	:
Branch Name	:
DP Code	:
IFSC No.	:
PAN NO of spouse	:
Contact Telephone No. :	
Mobile No :	
Contact Email ID of spouse	or
relative :	

The detailed information of myself is as under: [Please furnish in capital letters using black ink. Affix the signature below the Photograph.]

Sl. No	Full Name of Spouse & Staff No of the ex employee	Date of Birth (DD/MM/YYYY) Of Spouse	Gender	Relationship	Photograph
	Spouse				Spouse Signature

- 1. I have read and fully understood the contents of HO Circular 494/2019 dated 26.09.2019, 511/2019 dated 04.10.2019 & 565/2019 dated 07.11.2019 issued by Canara Bank conveying the renewal premium rates.
- 2. I am willing to opt for Medical Insurance Policy, <u>with Domiciliary Treatment coverage</u>, subject to payment of agreed Insurance Premium.
- 3. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme or administration of policy and Bank is only facilitating remittance of premium based on the mandate executed by me.
- 4. I authorize Canara Bank to debit the annual premium amount (presently Rs 82,373/- in case of Officer or Rs 61,784/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account as already indicated earlier to pay the premium now and in future also. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option / renewal of policy would be treated as lapsed.
- 5. I,Spouse of (Name of Retiree), Staff No. could not submit the option to renew/join the IBA Group Health Insurance for Retirees for 2019-20 on or before 31/10/2019 due to some unavoidable reasons. I hereby opt to join/renew the IBA Group Health Insurance for Retirees for 2019-20 and remit the full premium. I further agree that the period of coverage shall be from 01/12/2019 to 31/10/2020 subject to remittance of full premium.

Date:

[Signature]

Super Top up Policy without (Domiciliary)

- 1. I am consenting to take up the "Super Top up policy without OPD (Domiciliary) cover".
- 2. I authorize Canara Bank to debit the premium towards "Super Top up policy without OPD (Domiciliary) cover" (presently Rs 6,134/- in case of Officer or Rs 5,658/- in case of workmen) or such other higher premium amount in case of revision as informed by the insurance company from my account. I will ensure that sufficient balance is maintained in the account. I fully understand that in case sufficient balance is not maintained my option would be treated as lapsed

Date: