Annexure A

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

(Ex-Employees who had not opted earlier or opted and discontinued)

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 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 are as under: [Please furnish in capital letters using black ink. Affix the signature below the Photograph.]

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 552/2019 dated 23.10.2019 issued by Canara Bank conveying the renewal premium rates.

2. I am consenting to opt for the IBA Group Medical Insurance Policy, **Without Domiciliary Treatment coverage**, 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.

5. **I am aware that even though I am paying full premium as quoted by the Insurance Company, there will be a waiting period of 30 days (for utilization of policy benefits) from the commencement of the policy or from the date of remittance of premium, whichever is later.**

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:

[Signature]

Annexure B

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

(Spouses of Ex-Employees/deceased employees who had not opted earlier or opted and discontinued)

Name of the Spouse: _____
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 :	

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 552/2019 dated 23.10.2019 issued by Canara Bank conveying the renewal premium rates.

2. I am willing to opt for Medical Insurance Policy, without Domiciliary Treatment coverage, 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 am aware that even though I am paying full premium as quoted by the Insurance Company, there will be a waiting period of 30 days (for utilization of policy benefits) from the commencement of the policy or from the date of remittance of premium, whichever is later.**

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:

[Signature]

Annexure C

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

(Ex-Employees who had not opted earlier or opted and discontinued)

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 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 are as under: [Please furnish in capital letters using black ink. Affix the signature below the Photograph.]

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 552/2019 dated 23.10.2019 issued by Canara Bank conveying the renewal premium rates.

2. I am consenting to opt for IBA Group Medical Insurance Policy, **with Domiciliary Treatment coverage** 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.

5. **I am aware that even though I am paying full premium as quoted by the Insurance Company, there will be a waiting period of 30 days (for utilization of policy benefits) from the commencement of the policy or from the date of remittance of premium, whichever is later.**

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:

[Signature]

Annexure D

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

(Spouses of Ex-Employees/deceased employees Ex-Employees who had not opted earlier or opted and discontinued)

Name of the Spouse: _____
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 :	

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 552/2019 dated 23.10.2019 issued by Canara Bank conveying the renewal premium rates.

2. I am willing to opt for Medical Insurance Policy , with Domiciliary Treatment coverage, 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 am aware that even though I am paying full premium as quoted by the Insurance Company, there will be a waiting period of 30 days (for utilization of policy benefits) from the commencement of the policy or from the date of remittance of premium, whichever is later.**

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:

[Signature]