Annexure 1

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

From
Sri / Smt _____
Staff No._____
Mob No: _____
e mail id: _____

To
The Manager / Sr Manager
HRM Section
Circle Office, _____

Presently covered under
Domiciliary ☐ Non Domiciliary ☐

Please tick the appropriate box

(In case the renewal option is from spouse of deceased ex-employee the name and staff No. of ex-employee to be mentioned here:_____)

Residential Address: _____
_____

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 renew the 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, ... (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 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]

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: _____
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:	

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. Last year my spouse Sri / Smt _____( ), had opted for IBA Group Medical Group Insurance Policy & he/she has expired on _____ .
3. I am willing to renew the said Medical Insurance Policy, with Domiciliary Treatment coverage, subject to payment of agreed Insurance Premium.
4. 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.
5. 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.
6. 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:

[Signature]

Annexure 2

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

From
Sri / Smt _____
Staff No._____
Mob No: _____
e mail id: _____

To
The Manager / Sr Manager
HRM Section
Circle Office, _____

Presently covered under
Domiciliary ☐ Non Domiciliary ☐

Please tick the appropriate box

(In case the renewal option is from spouse of deceased ex employee the name and staff No. of ex employee to be mentioned here:_____)

Residential Address: _____
_____

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 renew 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, ... (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:

[Signature]

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 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:	

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. Last year my spouse Sri / Smt _____( ), had opted for IBA Group Medical Group Insurance Policy & he/she has expired on _____ .
3. I am willing to renew the said Medical Insurance Policy, without Domiciliary Treatment coverage, subject to payment of agreed Insurance Premium by me.
4. 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.
5. 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.
6. 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:

[Signature]

Annexure 3

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 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 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, **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, ... (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:

[Signature]

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: _____
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 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, 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, ...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:

[Signature]

Annexure 5

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._____
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 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, **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, ... (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 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 6

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: _____
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 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 , 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, ...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:

[Signature]