

## 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, _____
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Presently covered under	
Domiciliary <input type="checkbox"/>	Non Domiciliary <input type="checkbox"/>
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 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.

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 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.

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 <input type="checkbox"/> Non Domiciliary <input type="checkbox"/> Please tick the appropriate box
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(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 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.

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 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.

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]