Date: 09/03/2025

To,
LIC of India
Branch Office

Proposal No. 8515

Name of the Life to be assured RAJENDER

The Life to be assured was identified on the basis of

I have satisfied myself with regard to the identity of the Life to be assured before conducting tests / examination for which reports are enclosed. The Life to be assured has signed as below in my presence.

Signature of the Pathologist/ Doctor

Dr. RAINA KHAN
MBBS, DMRD
Reg. No. 25508

Name:

I confirm, I was on fasting for last 10 (ten) hours. All the Examination / tests as mentioned below were done with my consent.

(Signature of the Life to be assured)

Name of life to be assured:

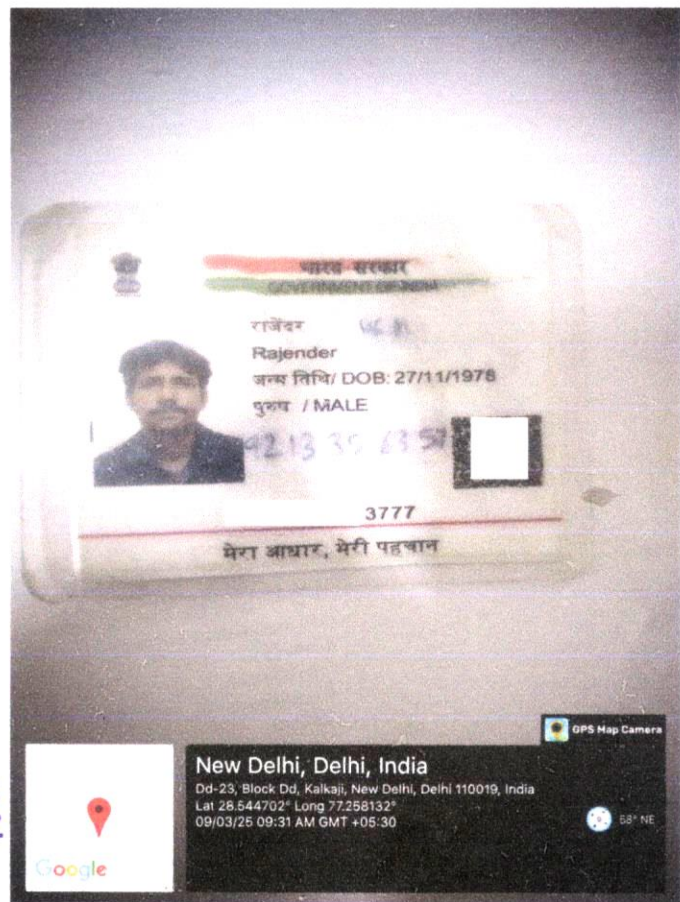
Reports Enclosed:

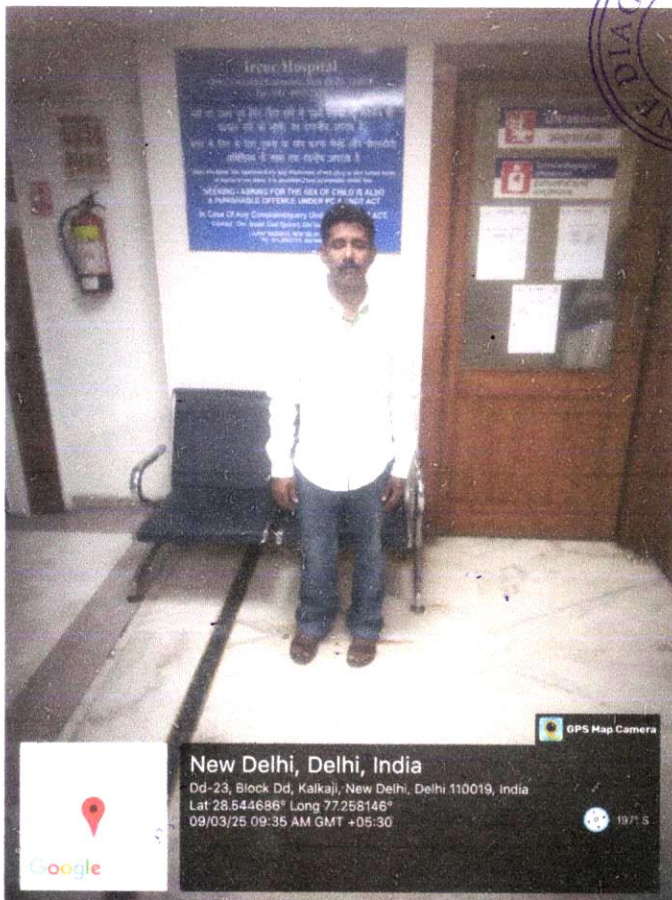
Reports Name	Yes/No	Reports Name	Yes/No
ELECTROCARDIOGRAM		PHYSICIAN'S REPORT	
COMPUTERISED TREADMILL TEST		IDENTIFICATION & DECLARATION FORMAT	
HAEMOGRAM		MEDICAL EXAMINER'S REPORT	✓
LIPIDOGRAM		BST (Blood Sugar Test-Fasting & PP) Both	
BLOOD SUGAR TOLERANCE REPORT		FBS (Fasting Blood Sugar)	
SPECIAL BIO-CHEMICAL TESTS - 13 (SBT-13)		PGBS (Post Glucose Blood Sugar)	
ROUTINE URINE ANALYSIS		Proposal and other documents	
REPORT ON X-RAY OF CHEST (P.A. VIEW)		Hb%	
ELISA FOR HIV		Other Test Deformity Questionnaire	

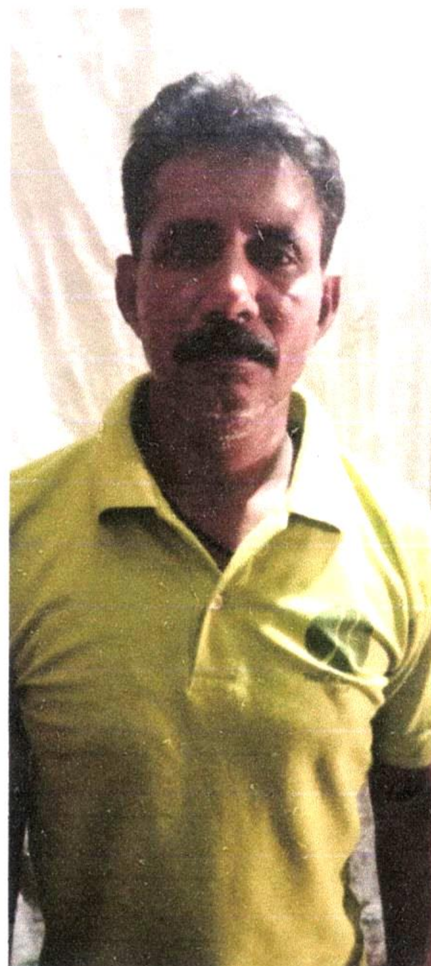
Comment Medsave Health Insurance TPA Ltd.

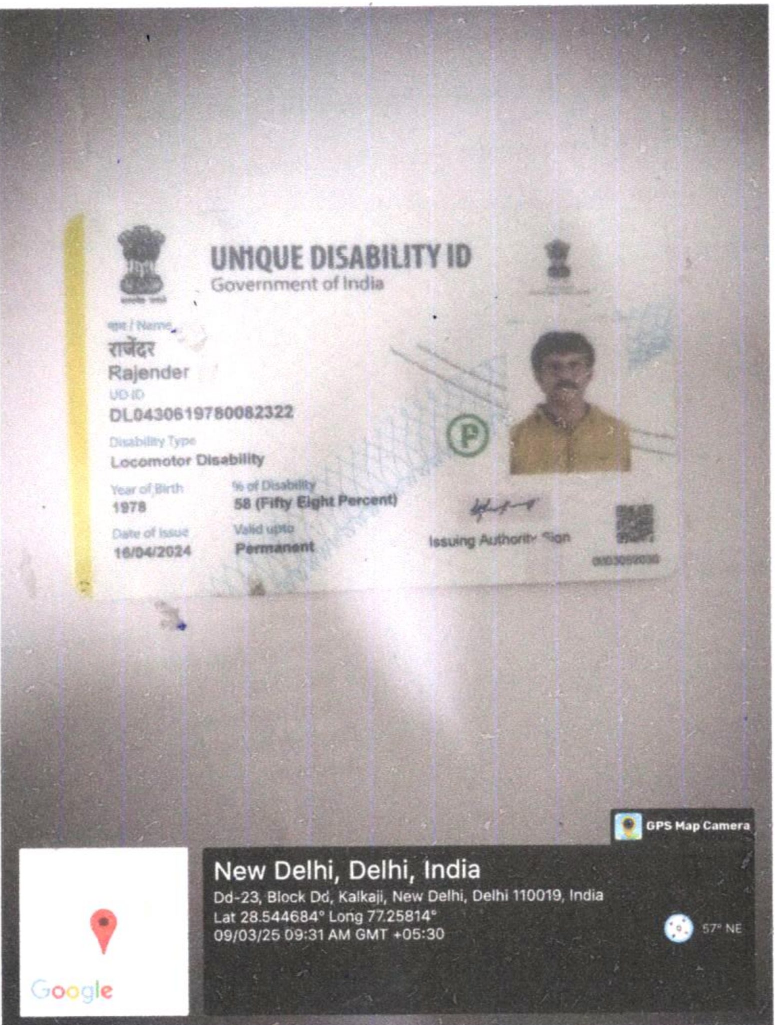
Authorized Signature,

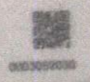
Dr. RAINA KHAN
MBBS, DMRD
Reg. No. 23508











Dr. RAINA KHAN
MBBS
Reg. No. 25508

MEDICAL EXAMINER'S REPORT
Form No LIC03-001(Revised 2020)

Branch Code:	
Proposal/ Policy No:	8515
MSP name/code :	
Date& Time of Examination:	
Medical Diary No & Page No:	

Mobile No of the Proposer/Life to be assured: ____________
Identity Proof verified: UID ____________ ID Proof No. 3777 ____________
(In Case of Aadhaar Card , please mention only last four digits}

[Note: Mobile number and identity proof details to be filled in above . For Physical MER, Identity Proof is to be verified and stamped.]

For Tele/ Video MER, consent given below is to be recorded either through email or audio/video message. For Physical Examination the below consent is to be obtained before examination.

"I would like to inform that this call with/ visit to Dr .... (Name of the Medical Examiner) is for conducting your Medical Examination through Tele/ Video/ Physical Examination on behalf of LIC of India".

Signature/ Thumb impression of Life to be assured
(In case of Physical Examination)

1	Full name of the life to be assured: RAJENDER		
2	Date of Birth: 27/11/1972	Age: 46-10	Gender: M
3	Height (In cms): 155	Weight (in kgs) : 50	
4	Required only in case of Physical MER		
	Pulse : 80/m	Blood Pressure (2 readings): 1. Systolic 126 Diastolic 80 2. Systolic 126 Diastolic 80	
	ASCERTAIN THE FOLLOWING FROM THE PERSON BEING EXAMINED If answer/s to any of the following questions is Yes, please give full details and ask life to be assured to submit copies of all treatment papers, investigation reports, histopathology report, discharge card, follow up reports etc. along with the proposal form to the Corporation		
5	a. Whether receiving or ever received any ***treatment/ medication*** including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any ***surgery / hospitalized*** for any medical condition / disability / injury due to accident? c. Whether visited the doctor any time in the last 5 years ? If answer to any of the questions 5(a) to (c)) is yes - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause iii. Name of Medicine iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration	Q-5 B H/o Lt leg polio since by birth (58% disability)	
6	In the last 5 years, if advised to undergo an X-ray/ CT scan / MRI / ECG / TMT / Blood test / Sputum/Throat swab test or any other investigatory or ***diagnostic tests***? Please specify date , reason ,advised by whom &findings.	No	
7	Suffering or ever suffered from ***Novel Coronavirus (Covid-19)*** or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flu-like tiredness), Rhinorrhea (mucus discharge from the nose), Sore throat, Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days. If yes provide all investigation and treatment reports	No	

8	a. Suffering from ***Hypertension*** (high blood pressure) or ***diabetes*** or blood sugar levels higher than normal or history of sugar /albumin in urine? b. Since when, any follow up and date and value of last checked blood pressure and sugar levels? c. Whether on medication? please give name of the prescribed medicine and dosage d. Whether developed any complications due to diabetes? e. Whether suffering from any other ***endocrine disorders*** such as thyroid disorder etc.? f. Any weight gain or weight loss in last 12 months (other than by diet control or exercise)?	No
9	a. Any history of chest pain, ***heartattack***, palpitations and breathlessness on exertion or irregular heartbeat? b. Whether suffering from ***high cholesterol*** ? c. Whetheron medication for any heart ailment/ high cholesterol? Please state name of the prescribed medicine and dosage. d. Whether undergone Surgery such as CABG, open heart surgery or PTCA?	No
10	Suffering or ever suffered from any disease related to ***kidney*** such as kidney failure, kidney or ureteral stones, blood or pus in urine or prostate?	No
11	Suffering or ever suffered from any ***Liver disorders*** like cirrhosis, hepatitis, jaundice, or disorder of the Spleen or from any ***lung related*** or respiratory disorders such as Asthma, bronchitis, wheezing, tuberculosis breathing difficulties etc.?	No
12	Suffering or ever suffered from any ***Blood disorder*** like anaemia, thalassemia or any Circulatory disorder?	No
13	Suffering or ever suffered from any form of ***cancer***, leukaemia, tumor, cyst or growth of any kind or enlarged lymph nodes?	No
14	Suffering or ever suffered from Epilepsy, ***nervous disorder***, multiple sclerosis, tremors, numbness, paralysis, brain stroke?	No
15	Suffering or ever suffered from any ***physical impairment***/ disability /amputation or any congenital disease/abnormality or disorder of back, neck, muscle, joints, bones, arthritis or gout?	h/o (Rt) Leg Polio Since Bybirth (58 % disability)
16	Suffering or ever suffered from Hernia or ***disorder of the Stomach*** / intestines, colitis, indigestion, Peptic ulcer, piles, or any other disease of the gall bladder or pancreas?	No
17	a. Suffering from Depression/Stress/ Anxiety/ Psychosis or any other Mental / ***psychiatric disorder***? b. Whether on treatment or ever taken any treatment, if yes, please give details of treatment, prescribed medicine and dosages	No
18	Is there any ***abnormality*** of Eyes (partial/total blindness),Ears (deafness/ discharge from the ears), Nose, Throat or Mouth,teeth, swelling of gums / tongue, tobacco stains or signs of oral cancer?	No
19	Whether person being examined and/ or his/her spouse/partner tested positive or is/ are under treatment for ***HIV /AIDS/Sexually transmitted diseases*** (e.g. syphilis, gonorrhea, etc.)	No
20	Ascertain if any other condition / disease / adverse habit (such as ***smoking/ tobacco chewing/ consumption of alcohol/drugs*** etc) which is relevant in assessment of medical risk of examinee.	No

For Female Proponents only		
i.	Whether pregnant? If so duration.	NA
ii	Suffering from any pregnancy related complications	
iii	Whether consulted a gynaecologist or undergone any investigation, treatment for any gynaec ailment such as fibroid, cyst or any disease of the breasts, uterus, cervix or ovaries etc. or taken / taking any treatment for the same	

FROM MEDICAL EXAMINER'S OBSERVATION/ASSESSMENT WHETHER LIFE TO BE ASSURED APPEARS MENTALLY AND PHYSICALLY HEALTHY	Yes

Declaration

You Mr/Ms ____________________declare that you have fully understood the questions asked to you during the call / Physical Examination and have furnished complete, true and accurate information after fully understanding the same. We thank you for having taken the time to confirm the details. The information provided will be passed on to Life Insurance Corporation of India for further processing.

Ramy

Signature/ Thumb impression of Life to be assured
(In case of Physical Examination)

I hereby certify that I have assessed/ examined the above life to be assured on the 09 day of 03 2025 vide Video call / Tele call/ Physical Examination personally and recorded true and correct findings to the aforesaid questions as ascertained from the life to be assured.

Place: Delhi
Date: 09/03/2025

Signature of Medical Examiner
Name & Code No:
Stamp:

Dr. RAINA KHAN
MBBS, DMRD
Reg. No. 25508

(Revised – 2006)

Division ____________ Branch Office ______________

DEFORMITY QUESTIONNAIRE

Name of the proponent / Life Assured RAJENDER Age 46yrs Years

Questions to be answered by the proponent's / policyholder's Personal Medical Attendant / Medical Examiner regarding Deformity/ies and / or Impairment/s

1.	a. What is the cause of deformity? Whether it is i. Congenital ii. Due to an accident or injury iii. Due to any underlying disease?	No (Lt) Leg Polio since by Birth (58% disability) No No
	b. Since when the deformity is present? Since by Birth	– 58 present
2.	If the deformity is due to any underlying disease, please state the following: i. What was the disease leading to deformity? ii. When did it occur? iii. Whether the disease is stationery or progressive? iv. If stationery, since when	(Lt) Leg Polio By Birth stationary By Birth
3.	Does he/she have control on bowel movements and bladder?	Yes
4.	Exact parts of the body affected and extent	(Lt) Leg Polio (58 present)
5	Are there any restrictions in movements and function of the limbs or affected parts? Please give degree of disability	(Lt) Leg Polio (58 present)
6.	Has he/she a limp?	Yes
7.	Whether he /she can walk and run fast without any aid (in case of deformity in the leg)?	No (Lt) Leg Polio
8.	Can he/she squat, sit and get up properly?	Yes
9.	Whether the affected limb is shorter than the other , and if so, to what extent (in cms)	5 Cm
10.	If the deformity is due to poliomyelitis, please state whether the wasting of muscles is i. mild ii. moderate iii. severe	No No Severe

11.	How many limbs are affected?	Rt leg (58 present)
12	Are there any respiratory complications? If yes, give details	Rt leg Polio
13	Is there any restriction in movement of any of the fingers? Are any of the fingers removed? If so, upto which phalanx. Whether thumb and forefinger have been affected / removed?	NO
14	a. Whether he / she can lift articles without any difficulty and hold the articles without losing the grip (in case of deformity in the hands)? b. Is the grip firm and strong?	YES
15	Are there any residual complications?	NO

My diagnosis as to the cause of the disability is NO

I do for the reasons explained below / do not have any reason to suspect on clinical grounds a recent deterioration causing more pronounced disability:

a. He / she is able / not able to perform routine self-care activities. Yes able

b. He / she is / is not required to use wheel chair / crutches. NO

c. Any other factors which are likely to add to the risk on account of the deformity / ies. NO

Please submit details of previous treatment, previous special reports, x-rays etc. for perusal and return.

Dated at DELHI on the 09 day of 03 2025.

Signature of the proposer / Policyholder

Signature of the Medical Examiner / Medical Attendant
Code No.
Qualifications
Registration No.
Address

Dr. RAINA KHAN
MBBS, DMRD
Reg. No. 25508