

# LIFE INSURANCE CORPORATION OF INDIA

## JUVENILE FMR

Zone \_\_\_\_\_ Division \_\_\_\_\_ Branch \_\_\_\_\_

Proposal No. 9453

Agent/D.O. Code: \_\_\_\_\_ Introduced by: \_\_\_\_\_ (name & signature)

Name of the child: (Master/ Miss) <u>NAVYA SHARMA</u>				
Mark of identification: Mole/Scar/any other (specify location) <u>NO</u>				
Current ID provided	Student	Passport	Latest School Report Card	Others(specify) <u>UTD</u>
Age of the child: <u>14</u> Years/Months <u>09</u> SEX: M <input type="checkbox"/> / F <input checked="" type="checkbox"/>				
Birth History: FTND / Forceps / Caesarean/ Other ( Please tick the relevant) <u>Normal</u>				
<b>A. Details of Physical Examination</b>				
<b>For all children:</b>				
Height of the child: <u>154</u> cms		Weight of the child: <u>36.6</u> kgs		
Pulse and character <u>76/M</u>		Blood Pressure <u>110/70</u> mm of Hg		
Presence of any congenital defects or abnormalities: Yes / <u>No</u> ( If yes, please provide details)				
<b>For Children Below 2 yrs:</b>				
Head Circumference _____ cms		Chest Circumference _____ cms		
<b>B. Medical History:</b>				
1) Is the proposed insured presently in good health?		Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>		
2) Does the proposed insured have any physical and mental handicap or deformity?		Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> If yes provide details:		
3) Has the proposed insured been hospitalized and/or has been advised for any treatment/surgery and/or has undergone any general checkup in the last five years?		Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> If yes provide details of the tests conducted and treatment if any.		
4) Has the proposed insured ever been treated or hospitalized for any Heart ailment/cancer/ kidney disorder/ epilepsy/ mental disorder/ diabetes/ musculoskeletal disorder/ blood disorder/ respiratory disorder like Bronchitis or Asthma/congenital or hereditary disorder		Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> If yes provide details:		
5) Is the child's behavior / appearance / mental ability in line with his current age?		Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> If yes provide details:		
6) If school going, has proposed insured taken any sick leave from school in the last 2 years?		Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> If yes provide details:		
7) Please give details of proposed insured's family history : Is any family member/s either suffering or have suffered or have died from heart disease, thalassaemia, cancer, kidney disease, any other hereditary / familial disorders		Father: _____ Mother : _____ Sibling 1 <u>NO</u> Sibling 2 _____		
<b>C. Immunization History: (Mandatory for ages &lt; and equal to 5 yrs)</b>				
Vaccinated for				
1. OPV:	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	2. DPT:	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	
3. BCG:	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	4. Hepatitis B:	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	
5. Mumps, Measles, Rubella:	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	6. Typhoid (above 1 Yr):	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	
7. Hepatitis A ( Above 1 Yr):	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>			



D. Medical Examination			If yes please elaborate
Do you find any evidence of abnormality, disease or surgery of:			
1) the respiratory system?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
2) the central and peripheral nervous system?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
3) the genito urinary system?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
4) the abdominal organs?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
5) the head, face, mouth, throat, eyes, ears, nose and neck?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
6) the skin, muscles, bones and joints?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
7) The Cardiovascular system:			
a) Are the peripheral pulses normal?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
b) Is there any evidence of heart enlargement?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
c) Are there murmurs or abnormal heart sounds?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
d) Do you suspect any abnormality of the cardiovascular system?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	

**Declaration by the parent accompanying the child:**

I hereby confirm that all facts regarding the child as recorded by the doctor are true and complete.

Signature of the parent: *Ashutosh* Name of the parent Dr. Ashutosh Sharma

**Doctor's Declaration**

- I hereby confirm that I have, this day, examined the above individual personally, in private and recorded the above information in my own handwriting. I certify that I have personally recorded the history as informed by the examinee/parent accompanying the child.
- Place of Examination: Clinic  Examinee's Residence
- I declare that the examinee has signed/affixed his/her thumb impression in my presence.

Dated at DELHI on the 08 day of MARCH 2005 at \_\_\_\_\_ a.m./p.m.

*Danye*  
Signature / thumb impression  
of the examinee

*3*  
Signature of the Medical Examiner  
Name & Address **BINDU**  
Qualification **MBBS, MD**  
Code: **Reg. No.-33435**  
Limit

**Confidential Comments from Doctor**

Are there any points on which you suggest further information be obtained? YES  NO

- For physical investigations
- For mental level assessment





सत्यमेव जयते

भारत सरकार

Government of India



आधार

Issue Date: 25/08/2013



डा० आशुतोष शर्मा

Dr Ashutosh Sharma

जन्म तिथि / DOB : 19/12/1977

पुरुष / Male



6741 4036 7566



6741 4036 7566

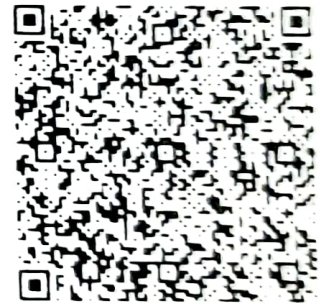
मेरा आधार, मेरी पहचान



भारत सरकार  
GOVERNMENT OF INDIA



नव्या शर्मा  
Navya Sharma  
जन्म तिथि / DOB : 27/05/2010  
महिला / FEMALE




**8213 8743 9241**

**आधार** - आम आदमी का अधिकार

**E** ELITE  
DIAGNOS



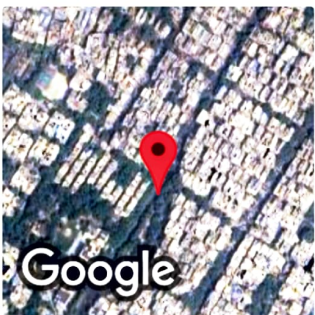
 GPS Map Camera

Delhi, Delhi, India

11883/11, Nehru Nagar, Sat Nagar, Karol Bagh, Delhi, Delhi 110005,  
India


Lat 28.648823° Long 77.182582°

08/03/2025 10:35 AM GMT +05:30



**E** ELITE  
DIAGNO



 **GPS Map Camera**

**Delhi, Delhi, India**

11883/11, Nehru Nagar, Sat Nagar, Karol Bagh, Delhi, Delhi 110005,  
India

Lat 28.648819° Long 77.182589°  
08/03/2025 10:37 AM GMT +05:30

