



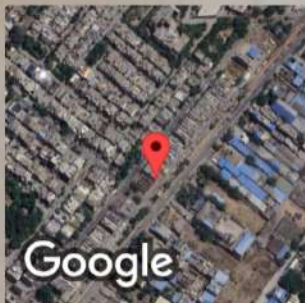
 भारत सरकार  
GOVERNMENT OF INDIA  आधार

 Karn Kumar  
जन्म तिथि / DOB: 14/10/1993  
पुरुष / MALE  
Mobile No.: 9555203132

**8174 3235 2337**

**मेरा आधार, मेरी पहचान**

 GPS Map Camera



Google

## Gurugram, Haryana, India

Sco-72, Market Of Sector 10a, Sector 10a,  
Gurugram, Haryana 122101, India

Lat 28.44141° Long 77.008199°

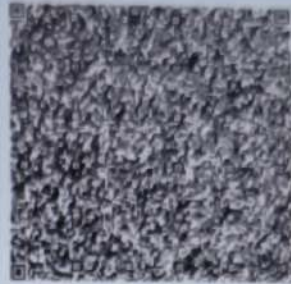
12/03/25 12:49 PM GMT +05:30



नामांकन क्रम/ Enrolment No.: 2830/08485/05828

To  
विवांन कुमार  
Vivan Kumar  
C/O: Kam Kumar,  
209E,  
Near Shiv Murti Chowk,  
Pratap Nagar,  
VTC: Gurgaon,  
PO: Gurgaon,  
Sub District: Gurgaon,  
District: Gurgaon,  
State: Haryana,  
PIN Code: 122001,  
Mobile: 7004585214

बाल आधार



आपका आधार क्रमांक / Your Aadhaar No. :

7686 8345 1103

VID : 9175 1427 7651 9496

मेरा आधार, मेरी पहचान



भारत सरकार  
Government of India



बाल आधार

Aadhaar no. issued: 12/03/2025



विवांन कुमार  
Vivan Kumar  
जन्म तिथि/DOB: 14/12/2023  
पुरुष/ MALE

पहले आधार 5 वर्ष की उम्र तक ही वैध है।

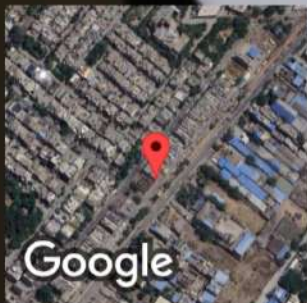
आधार पहचान का प्रमाण है, नागरिकता या जन्मतिथि का नहीं।  
इसका उपयोग सरकारी (ऑनलाइन प्रमाणीकरण, या वेधुआर कोष/  
ऑनलाइन एम्प्लॉयमेंट की स्कैनिंग) के साथ किया जाना चाहिए।

Aadhaar is proof of identity, not of citizenship  
or date of birth. It should be used with verification (online  
authentication, or scanning of QR code / offline XML).

7686 8345 1103

मेरा आधार, मेरी पहचान

GPS Map Camera



Gurugram, Haryana, India

Sco-72, Market Of Sector 10a, Sector 10a,

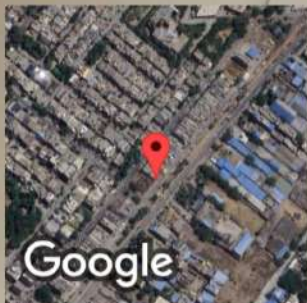
Gurugram, Haryana 122101, India

Lat 28.44141° Long 77.008204°

12/03/25 12:53 PM GMT +05:30



 GPS Map Camera



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# Gurugram, Haryana, India

Sco-72, Market Of Sector 10a, Sector 10a,  
Gurugram, Haryana 122101, India

Lat 28.441413° Long 77.00821°

12/03/25 01:09 PM GMT +05:30

Dear Metagen Healthcare

We have received a booking request with the following details. Provide your confirmation by clicking on the Yes button.

You confirm this booking? Yes No

Name : VIVAN KUMAR

Proposal No : 7677

Branch Code : 122

Contact Details : 9555203132

Location : 73, Sector 10 A, SBI Bank,  
Gurgaon, Haryana - 122011

Appointment Date : 13-03-2025

Member Information		
Booked Member Name	Age	Gender
VIVAN KUMAR	1 year	M

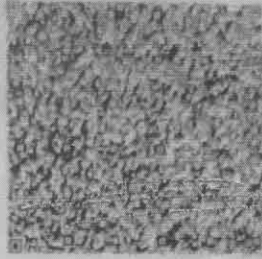
**Included Test -**

- Physical Medical Examination Report (PMER)  
Rs. 50,00,000 to Rs 99,99,999



आधार क्रमांक / Aadhaar No. 2830/08485/05828

शिवान कुमार  
Vishan Kumar  
1/27, Kirti Khera,  
2009,  
Near Shiv Mandi Chowk,  
Punjab Nagar,  
VTC, Gurugram,  
NCT of Haryana,  
Sub District: Gurugram,  
District: Gurugram,  
State: Haryana,  
PIN Code: 122001,  
Mobile: 904585214



आपका आधार क्रमांक / Your Aadhaar No.

~~XXXXXXXXXXXX~~ 5 1103  
UID: 9175 1427 7651 9496

Dr. RAJIV DO  
MBBS  
Consultant Phys  
Reg. No. MCI/33

मेरा आधार, मेरी पहचान



भारत सरकार  
Government of India



शिवान कुमार  
Vishan Kumar  
जन्म तिथि/DOB: 14/12/2023  
पुरुष/ MALE

यह आधार 5 वर्ष की उम्र तक ही वैध है।

आधार पहचान का प्रमाण है, नागरिकता या जन्मतिथि का नहीं।  
इसका उपयोग सरकारों (ऑनलाइन प्रशासनिक सेवा, या नज्दिक परिसर,  
ऑनलाइन सार्वजनिक सेवा प्रदाता) के साथ किया जा सकता है।  
Aadhaar is proof of identity, not of citizenship  
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authentication, or scanning of QR code / offline XML).

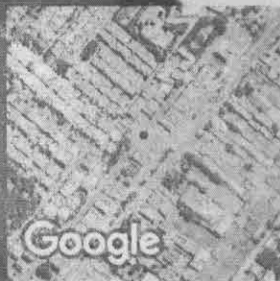
~~XXXXXXXXXXXX~~ 1103

मेरा आधार, मेरी पहचान

*Vishan Kumar*



GPS Map Camera



Gurugram, Haryana, India

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Gurugram, Haryana 122101, India  
Lat 28.44141° Long 77.008204°  
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भारत सरकार  
GOVERNMENT OF INDIA

आधार



Karn Kumar  
जन्म तिथि / DOB: 14/10/1993  
पुरुष / MALE  
Mobile No.: 9655203132

~~XXXXXXXXXXXX~~ 2337

*father's ID*

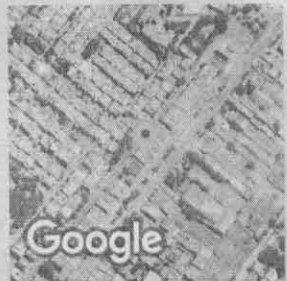
मेरा आधार, मेरी पहचान

*Karn Kumar*

DR. RAJIV DOGRA  
MBBS, MD  
Consultant Physician  
Reg. No. MCI/31434



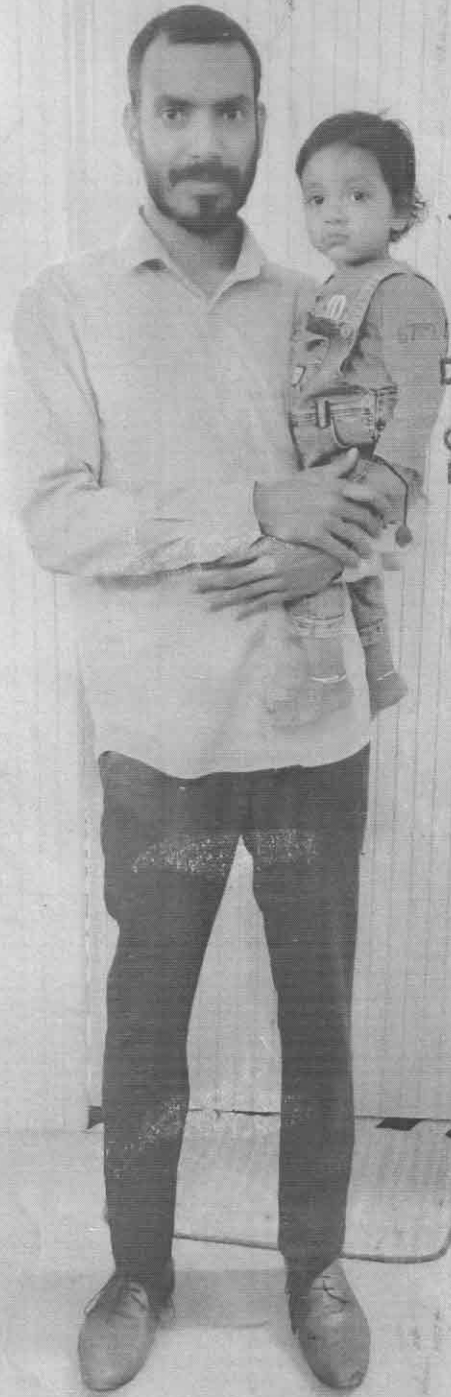
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Viyan with father



Dr. RAJIV DOGRA  
MBBS, MD  
Consultant Physician  
Reg. No. MCI/31434



*Raun Kumar*

*(Father)*

GPS Map Camera



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Lat 28.441413° Long 77.00821°

12/03/25 01:09 PM GMT +05:30

Date: 12/03/2025

To, 122  
LIC of India  
Branch Office

Proposal No. 7677

Name of the Life to be assured VIJAN KUMAR

The Life to be assured was identified on the basis of AADHAR

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.

MBBS, MD  
Consultant Physician  
Reg. No. MCI/31134  
Signature of the Pathologist/ Doctor



Name:

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

Vijan Kumar (Father)

(Signature of the Life to be assured)

Name of life to be assured:

**Reports Enclosed:**

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

**Comment Medsave Health Insurance TPA Ltd.**

Authorized Signature,



**LIFE INSURANCE CORPORATION OF INDIA**

**JUVENILE FMR**

Zone

Division

Branch **122**

Proposal No. **7677**

Agent/D.O. Code:

Introduced by: (name & signature)

Name of the child: (Master/ Miss) <b>VIVAN KUMAR</b>			
Mark of identification: Mole/Scar/any other (specify location) <b>NONE SPECIFIC MARK</b>			
Current ID provided	Student	Passport	Latest School Report Card <input checked="" type="checkbox"/> Others(specify) <b>AADHAR - 1103</b>
Age of the child: <b>1</b> Years/Months		SEX: M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
Birth History: FTND / Forceps / Caesarean/ Other ( Please tick the relevant)			
<b>A. Details of Physical Examination</b>			
<b>For all children:</b>			
Height of the child: <b>72</b> cms		Weight of the child: <b>10</b> kgs	
Pulse and character <b>80 min/eqm</b>		Blood Pressure <b>98/62</b> mm of Hg	
Presence of any congenital defects or abnormalities: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> ( If yes, please provide details)			
<b>For Children Below 2 yrs:</b>			
Head Circumference <b>46</b> cms		Chest Circumference <b>49</b> cms	
<b>B. Medical History:</b>			
1) Is the proposed insured presently in good health?		Yes <input 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 checked="" type="checkbox"/> / No <input 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: <b>31, Healthy</b> Mother: <b>28, Healthy</b> Sibling 1 <b>J No</b> Sibling 2 <b>J No</b>	
<b>C. Immunization History: (Mandatory for ages &lt; and equal to 5 yrs)</b>			
Vaccinated for			
1. OPV:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	2. DPT:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>
3. BCG:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	4. Hepatitis B:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>
5. Mumps, Measles, Rubella:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	6. Typhoid (above 1 Yr):	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>
7. Hepatitis A ( Above 1 Yr) :	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>		

D. Medical Examination			
Do you find any evidence of abnormality, disease or surgery of:			If yes please elaborate
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 checked="" type="checkbox"/> Yes	<input 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: Karn Kumar Name of the parent: KARN KUMAR

#### 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 Gurgaon on the 12 day of 03 2008 at 01:09 a.m./p.m.

Signature / thumb impression  
of the examinee

Dr. RAJVI DOGRA  
MBBS, MD  
Consultant Physician  
Signature of the Medical Examiner  
Name & Address  
Qualification  
Code:  
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