



No. **99**

Branch Code:	<b>383</b>
Proposal/ Policy No:	<b>12790</b>
MSP name/code :	<b>020003</b>
Date & Time of Examination:	<b>23-11-24/10:00 AM</b>
Medical Diary No & Page No:	

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

**124**

Mobile No of the Proposer/Life to be assured: **7090554247**  
Identity Proof verified: **Aadhaar Card** ID Proof No: **1367**

(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 **Suman Rao** (Name of the Medical Examiner) is for conducting your Medical Examination through Tele/ Video/ Physical Examination on behalf of LIC of India".

*[Signature]*

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

1. Full name of the life to be assured: **Ashtami Raut**

2. Date of Birth: **20-8-1963** Age: **61** Gender: **F**

3. Height (In cms): **150** Weight (in kgs): **69**

4. Required only in case of Physical MER

Pulse: **60** Blood Pressure (2 readings):  
1. Systolic **120** Diastolic **70**  
2. Systolic **120** Diastolic **70**

**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.	<p>a. Whether receiving or ever received any <b>treatment medication</b> including alternate medicine like Ayurveda, homeopathy etc. ?</p> <p>b. Undergone any <b>surgery / hospitalized</b> for any medical condition / disability / injury due to accident?</p> <p>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 -</p> <p>i. Date of surgery/accident/injury/hospitalization</p> <p>ii. Nature and cause</p> <p>iii. Name of Medicine</p> <p>iv. Degree of impairment if any</p> <p>v. Whether unconscious due to accident, if yes, give duration</p>	<p><b>NO</b></p>
6.	<p>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 <b>diagnostic tests</b>?</p> <p>Please specify date, reason, advised by whom &amp; findings.</p>	<p><b>NO</b></p>
7.	<p>Suffering or ever suffered from <b>Novel Coronavirus (Covid-19)</b> 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 diarrhea, 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</p>	<p><b>NO</b></p>
8.	<p>a. Suffering from <b>Hypertension</b> (high blood pressure) or <b>diabetes</b> or blood sugar levels higher than normal or history of sugar/albumin in urine?</p> <p>b. Since when, any follow up and date and value of last checked blood pressure and sugar levels?</p> <p>c. Whether on medication? please give name of the prescribed medicine and dosage</p> <p>d. Whether developed any complications due to diabetes?</p> <p>e. Whether suffering from any other <b>endocrine disorders</b> such as thyroid disorder etc.?</p> <p>f. Any weight gain or weight loss in last 12 months (other than by diet control or exercise)?</p>	<p><b>NO</b></p>





9.	a. Any history of chest pain, <b>heart attack</b> , palpitations and breathlessness on exertion or irregular heartbeat? b. Whether suffering from <b>high cholesterol</b> ? c. Whether on 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 <b>kidney</b> such as kidney failure, kidney or ureteral stones, blood or pus in urine or prostate?	NO
11.	Suffering or ever suffered from any <b>Liver disorders</b> like cirrhosis, hepatitis, jaundice, or disorder of the Spleen or from any <b>lung related</b> or respiratory disorders such as Asthma, bronchitis, wheezing, tuberculosis breathing difficulties etc.?	NO
12.	Suffering or ever suffered from any <b>Blood disorder</b> like anemia, thalassemia or any Circulatory disorder?	NO
13.	Suffering or ever suffered from any form of <b>cancer</b> , leukemia, tumor, cyst or growth of any kind or enlarged lymph nodes?	NO
14.	Suffering or ever suffered from Epilepsy, <b>nervous disorder</b> , 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?	NO
16.	Suffering or ever suffered from Hemia or <b>disorder of the Stomach / intestines</b> , 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 / <b>psychiatric disorder</b> ? 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 <b>abnormality</b> 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 <b>HIV/AIDS/Sexually transmitted diseases</b> (e.g. syphilis, gonorrhoea, etc.)	NO
20.	Ascertain if any other condition / disease / adverse habit (such as <b>smoking/ tobacco chewing/ consumption of alcohol/drugs</b> etc.) which is relevant in assessment of medical risk of examinee.	NO

<b>For Female Proponents only</b>		
i	Whether pregnant? If so duration.	NO
ii	Suffering from any pregnancy related complications	NO
iii	Whether consulted a gynecologist or undergone any investigation, treatment for any gynae ailment such as fibroid, cyst or any disease of the breasts, uterus, cervix or ovaries etc. or taken / taking any treatment for the same	NO

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

*Ashdani Raut*

**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.

*[Signature]*

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

23

I hereby certify that I have assessed/ examined the above life to be assured on the ..... day of 11 20 24 vide Video call / Tel call / Physical Examination personally and recorded true and correct findings to the aforesaid questions as ascertained from the life to be assured.

Place: 13/1/24  
Date: 23-11-2024  
Stamp:



**Dr. Subho Rao**  
MBBS, MD (D)  
Fellowship in Hemodialysis  
CGMC  
Name & Code No:  
Consultant Physician



भारत सरकार  
Government of India



Issue Date: 08/04/2015



अष्टमी राउत  
Ashtami Raut  
जन्म तिथि / DOB: 20/08/1963  
महिला / Female

~~1367~~ 1367

मेरा आधार, मेरी पहचान

*Ashtami*



MoN. 7000554247



भारतीय विशिष्ट पहचान प्राधिकरण  
Unique Identification Authority of India



Print Date: 26/12/2021

पता: द्वारा: रंजित राउत, डेंटल कॉलेज के पिछे, अंजोरा (ख),  
अंजोरा, दुर्ग, छत्तीसगढ़, 491001

Address: C/O: Ranjit Raut, Dental College Ke  
Pichhe, anjora (kh), Anjora, Durg,  
Chhattisgarh, 491001



~~1367~~ 1367

1947

help@uidai.gov.in

www.uidai.gov.in

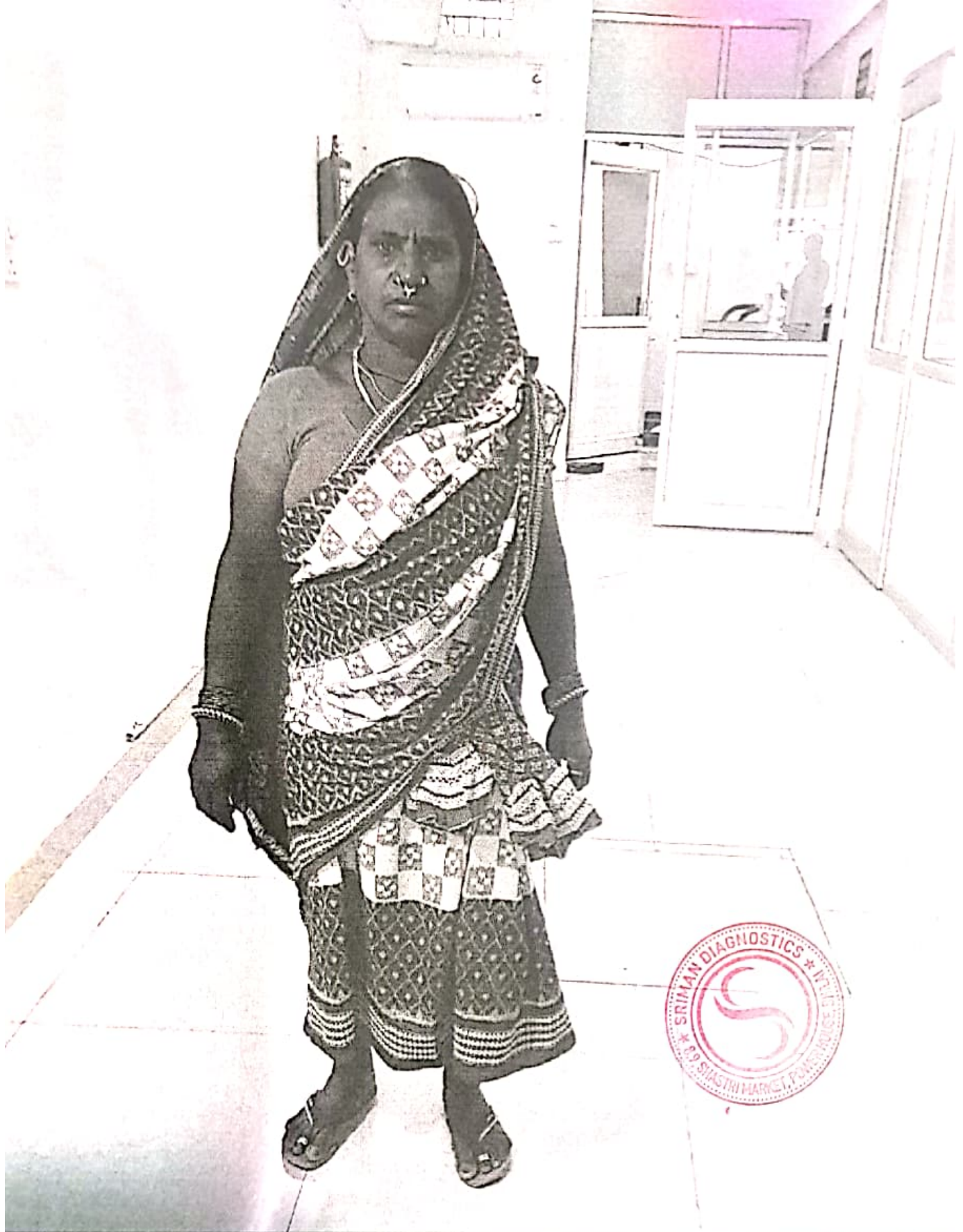


PHOTO COPY  
ATTESTED

SALIL JHA  
ADVOCATE, NATARY  
DURG (C.G.)  
L.N 6/10/15

10 OCT 2024





696H+GFM, Nandini Rd, Janjgiri,  
Bhilai, Chhattisgarh 490011,



27.01° 358 N

Lat: 21.211335, Long: 81.378901

23 Nov, 24, 09:54 am, Saturday



From No. LIC 03-

DIVISIONAL OFFICE, RAIPUR  
BLOOD SUGAR TOLERANCE REPORT

Full Name of the life to be Assured		MRS. ASHTAMI RAUT			
Age :	61	Sex:	F		
Division		Branch:	383		
Proposal No.	12790	Agent Code No.:		Dev. Officer code No.	
Introducer	Name	Designation/Club Membership	Signature (In full)		
Agent					
Second Introducer					

**Instruction for the Pathologist**

- I. The observation should be made in the morning in the fasting state before and after the ingestion of 75 grams of glucose.
- II. The pathologist should indicate the method of blood estimation employed and the normal values .
- III. Each column should be filled in every case.
- IV. Please insist on the proposer signing in your presence. A form on which the proposer has already put his signature should not be used.

Sample	O' Clock	Blood Sugar (%)	Urine Glucose (%)	Acetone Bodies	Normal Value
Fasting	10:00	103.6	---	---	65-110
2 hours after 75 gms of Glucose					

Instruction .....  
 Method of blood sugar estimation employed .....GOD...POD.....

I declare that the person examined/investigated, Signed/affixed thumb impression in the space earmarked below. In my presence and I am not related to him/her or the Agent or the Development officer

Dated at	Bhilai	on the	23	day of	11	2024	at	10:00	AM
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Signature of Thumb Impression of L.A.



Signature of the Pathologist :	<i>Dr. A. K. Singh</i>
Name of the Pathologist :	Dr. A. K. Singh
Qualification :	MBBS, MD (PATHOLOGY)
Name & Address of the Hospital/Clinic/Lab :	CGHS, Raipur/2014 Consultant Pathologist



ID: 28552

ASHTAMI RAUT

Female 61Years

kg

23-11-2024 15:12:05

HR : 60 bpm

P : 122 ms

PR : 144 ms

QRS : 88 ms

QT/QTc : 434/434 ms

PQRS/T : 86/22/56 °

RV5/SV1 : 0.336/0.595 mV

Diagnosis Information:

Sinus rhythm

Poor R wave progression

Borderline ECG

*Ashtami*

**Dr. Suman Rao**

MBBS, MD (MED)

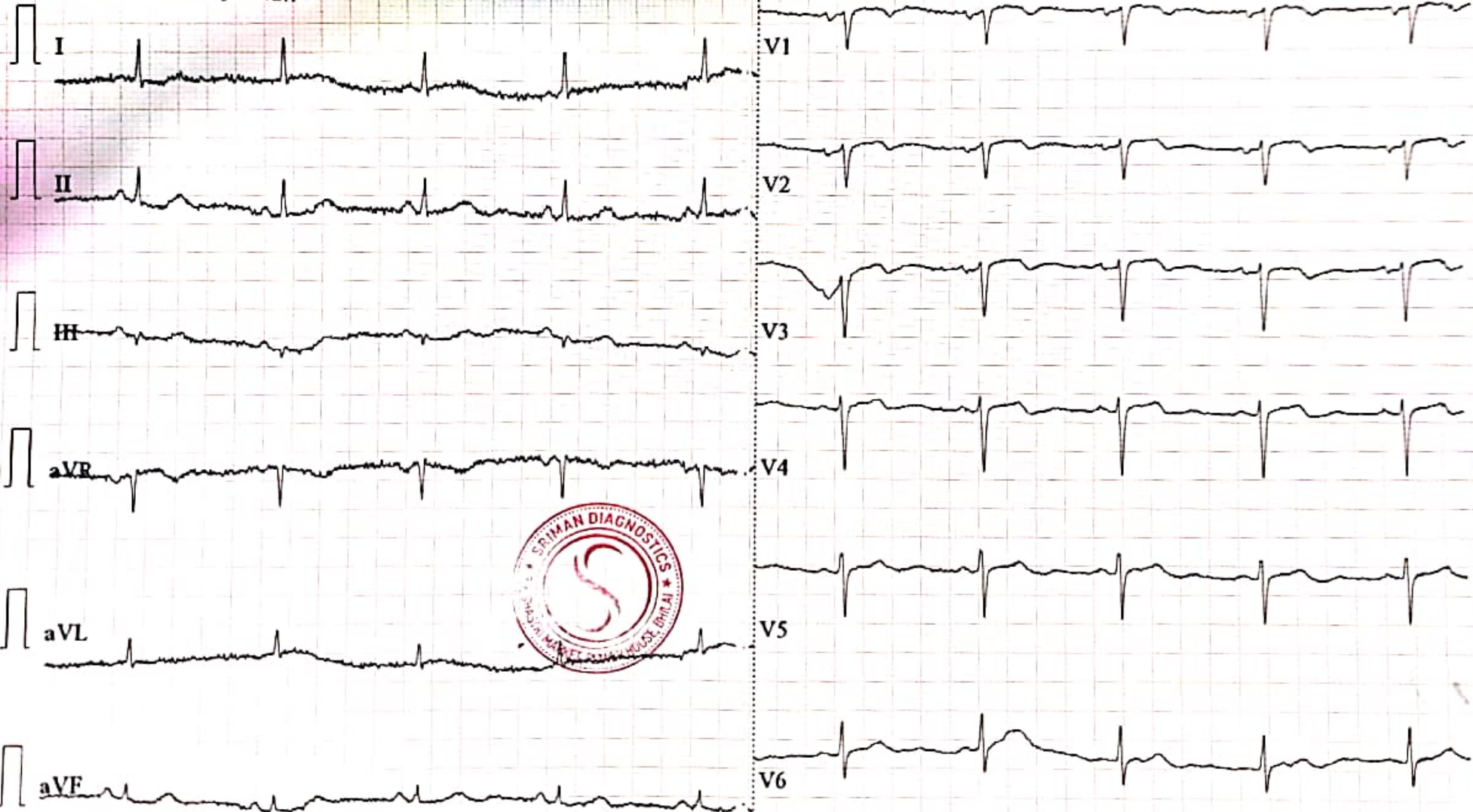
Fellowship in Haemodialysis

CGMC-1552/2008

Consultant Physician

Ref-Phys. : LIC

Report Confirmed by:





From No. LIC 03-

DIVISIONAL OFFICE, RAIPUR  
ELECTROCARDIOGRAM

Full Name of the life to be Assured		MRS. ASHTAMI RAUT	
Age :	61	Sex:	F
Division		Branch	383
Proposal No.	12790	Agent Code No.:	Dev. Officer code No.
Introducer	Name	Designation/Club Membership	Signature (In full)
Agent			
Second Introducer			

**Instruction to the Cardiologist**

- I. Please satisfy yourself about the identity of the examinee to guard against impersonation
- II. The examinee and the person's introducing him must sign in your presence Do not use the form signed in advance Also obtain signatures on ECG tracings
- III. The base line must be steady **The tracing must be pasted on a folder.**
- IV. Rest ECG should be 12 leads along with standardization slip each lead with minimum of 3 complexes. Long lead II If L-III and AVF shows deep Q or Twave change. They should be recorded additionally in deep inspiration, if V Shows a tall R -Wave. Additional lead VR be recorded

**DECLARATION**

I hereby declare that the foregoing answers are given by me after fully understanding the questions. They are true and complete and no information has been withheld. I do agree that these will form part of proposal dated ..... given by me to LIC of India

Signature of witness

Name of witness

Signature of Thumb Impression of L.A

Note - Cardiologist is requested to explain following questions to L.A and to note the answer there of

I. Have you ever had chest pain, palpitation, breathlessness at rest or exertion ?

II. Are you suffering from heart disease, diabetes, high or low Blood Pressure or Kidney diseases

III. Have you ever had Chest X-Ray, ECG. Blood Sugar. Cholesterol or any other test done ?

If the answer's to any all of the above questions is "yes" Submit all relevant papers with this form I declare that the person examined/investigated . signed/affix thumb impression

in the space earmarked below, in my presence and I am not related to him/her or the Agent or the Development officer .

Dated at **Bhilai** on the **23** day of **11** **2024** at **10:00** **AM**

Signature of Thumb Impression of L.A.



Signature of the Cardiologist: **Dr. Sunil Rao**  
 Name of the Cardiologist: **MBBS, MD (MED)**  
 Qualification: **Fellowship in Hemodialysis**  
 Name & Address of the Hospital/Consultant: **CGMC-15272006 Consultant Physician**





**Divisional Office, Raipur**

Full Name of the life to be Assured	<b>MRS. ASHTAMI RAUT</b>
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**(A) Measurements**

Height (Cm)	Weight (Kg)	Blood Pressure	Pulse Rate
<b>150</b>	<b>69</b>	<b>120/70</b>	<b>60</b>

**(B) Cardiovascular System**

.....  
 .....

**Rest ECG Report**

Position	<b>SUPINE</b>		P Wave	<b>NORMAL</b>	
Standard dictation 1 mv	<b>10 um</b>		PR Interval	<b>144</b>	<b>ms</b>
Mechanism	<b>Sinus</b>		QRS Complexes	<b>88</b>	<b>ms</b>
Voltage	<b>1 um</b>		Q-T Duration	<b>434/434</b>	<b>ms</b>
Electrical Axis	<b>CLEAR</b>		S-T Segment	<b>NORMAL</b>	
Auricular Rate	<b>60</b>	<b>bpm</b>	T-Wave	<b>NORMAL</b>	
Ventricular Rate	<b>60</b>	<b>bpm</b>	Q-Wave	<b>NORMAL</b>	
Rhythm	<b>Sinus Rhythm</b>				
Additional Findings, if Any	<b>No</b>				

**Conclusion**

.....**W.N.L.**.....  
 .....

Dated at	<b>Bhilai</b>	on the	<b>23</b>	day of	<b>11</b>	<b>2024</b>	at	<b>10:00</b>	<b>AM</b>
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Signature of Thumb Impression of L.A.



Signature of the Cardiologist	<b>Dr. Suman Rao</b>
Name of the Cardiologist	<b>MBBS, MD (D)</b>
Qualification :	<b>Fellowship in Hemodialysis</b>
Name & Address of the Hospital/Clinic/Lab	<b>Consultant Physician</b>