MEDICAL EXAMINER'S REPORT Form No LIC03-001(Revised 2020)	Branch Code: **122**
	Proposal/Policy No: **8847**
	MSP name/code : **18**
	Date& Time of Examination: **2025-03-13**
	Medical Diary No & Page No: **88**

Mobile No of the Proposer/Life to be assured: **9459056592**
Identity Proof verified: **Pan ID Proof No. GBMPS3002P**

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: **SHIVIKA SHARMA**		
2.	Date of Birth: **1991-10-30**	Age: **33 year**	Gender: **Female**
3.	Height (In cms): **176.00**	Weight (in kgs): **68.00**	
4.	Pulse: **0**	Blood Pressure (2 readings): 1. Systolic- Diastolic - **0** 2. Systolic- **0** Diastolic - **0**	
5.	1. Whether receiving or ever received any **treatment/ medication** including alternate medicine like ayurveda, homeopathy etc.? 2. Undergone any **surgery / hospitalized** for any medical condition / disability / injury due to accident? 1. Date of surgery/accident/injury/hospitalisation 2. Nature and cause 3. Name of Medicine 4. Degree of impairment if any 3. Whether visited the doctor any time in the last 5 years ?		• No • Yes 1. 2022-02-01 00:00:00 2. H/O CHOLECYSTECTOMY 3 YEARS BACK. 3. NA. 4. MINOR. • No
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.	1. Suffering from **Hypertension**(high blood pressure) or diabetes or blood sugar levels higher than normal or history of sugar /albumin in urine? 2. Since when, any follow up and date and value of last checked blood pressure and sugar levels 3. Whether on medication? please give name of the prescribed medicine and dosage 4. Whether developed any complications due to diabetes? 5. Whether suffering from any other **endocrine disorders**such as thyroid disorder etc.? 6. Any weight gain or weight loss in last 12 months (other than by diet control or exercise)?	No No No No No No
9.	• a. Any history of chest pain, **heart attack,** palpitations and breathlessness on exertion or irregular heartbeat? • b. Whether suffering from high **cholesterol** ? • 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 No No 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 disorders** like anemia, 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 enlargedlymph nodes?	No
14.	• Suffering orever 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?	No
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	1. Suffering from Depression/Stress/ Anxiety/ Psychosis or any other Mental / **psychiatric disorder**? 2. Whether on treatment or ever taken any treatment, if yes, please give details of treatment, prescribed medicine and dosages	No 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

1. **For Female Proponents only**		
i	• Whether pregnant? If so duration.	No
ii	• Suffering from any pregnancy related complications	No
iii	• Whether consulted a gynaecologist or undergone any investigation, treatment for any gynaecailment 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 L.A. APPEARS TO BE HEALTHY.

Declaration

You Mr/Ms **SHIVIKA SHARMA** declare that you have fully understood the questions asked to you during the call / Physical Examination and have furnished complete, true and accurate

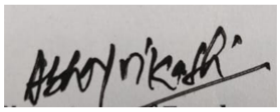
information after fully understanding the same.We thank you for having taken the time to confirm the details. The information provided will be passed on to Life Insurance Corporation of India for further processing.

Signature/ 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 **13** of **Mar 2025** ~~Tele call~~/ Video call/ ~~Physical Examination~~/ and recorded true and correct findings to the aforesaid questions as ascertained from the life to be assured.

- Place: Delhi
- Pincode: 110030
- Date: 13 Mar 2025

- Signature of Medical Examiner
- Name & Code No: Dr. Abhay Vikash,



DMC/R/20922

- Stamp: