ME473974556FH

आपका आधार क्रमांक / Your Aadhaar No. :

7852

मेरा आधार, मेरी पहचान

भारत सरकार

Government of India

मृदुला रश्मि किंडो

Mridula Rashmi Kindo

जन्म तिथि / DOB : 19/09/1975

महिला / Female

Medsave Health Insurance TPA Ltd. New Delhi

7852

मेरा आधार, मेरी पहचान

If undelivered please return to:

P. O. Box No. 1947, Bengaluru - 560 001

आपका आधार क्रमांक / Your Aadhaar No. :

[redacted] 4171

मेरा आधार, मेरी पहचान

भारत सरकार

Government of India

अद्विका जुडिथ कुजूर

Advika Judith Kujur

जन्म तिथि / DOB : 04/01/2007

महिला / Female

Medsave Health Insurance TPA Ltd. New Delhi

[redacted]

[redacted] 4171

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P. O. Box No. 1947, Bengaluru - 560 001


Medsave Health Insurance TPA Ltd.
New Delhi
GPS Map Camera
New Delhi, Delhi, India
F24, Rocky Area, Stone Quarries, Rajpur Colony, New Delhi, Delhi 110068, India
Lat 28.490381°
Long 77.205257°
06/10/24 08:05 AM GMT +05:30
Google


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LIFE INSURANCE CORPORATION OF INDIA

JUVENILE FMR

Zone : NORTHERN | Division : Delhi D.O.-II | Branch

Proposal No. 2755

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

Name of the child: (Master/ Miss) ADVIKA JUDITH KUJUR				
Mark of identification: Mole/Scar/any other (specify location) No				
Current ID provided	Student	Passport	Latest School Report Card	Others(specify) UID- 4171
Age of the child: 17 Years/Months 09			SEX: M ☐ / F ☑	
Birth History: FTND / Forceps / Caesarean/ Other (Please tick the relevant) Normal				

A. Details of Physical Examination

For all children:

Height of the child: 157 cms Weight of the child: 45 kgs

Pulse and character 90/m Blood Pressure 110/76 mm of Hg

Presence of any congenital defects or abnormalities: Yes / No

(If yes, please provide details)

For Children Below 2 yrs:

Head Circumference 53 cms Chest Circumference 80 cms

B. Medical History:

1) Is the proposed insured presently in good health?	Yes ☑ / No ☐
2) Does the proposed insured have any physical and mental handicap or deformity?	Yes ☐ / No ☑ 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 ☐ / No ☑ 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 ☐ / No ☑ If yes provide details:
5) Is the child's behavior / appearance / mental ability in line with his current age?	Yes ☑ / No ☐ If no provide details:
6) If school going, has proposed insured taken any sick leave from school in the last 2 years?	Yes ☐ / No ☑ 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, thallassaemia, cancer, kidney disease, any other hereditary / familial disorders	Father: Mother : Sibling 1 No Sibling 2

C. Immunization History: (Mandatory for ages < and equal to 5 yrs)

Vaccinated for			
1. OPV:	Yes ☑ / No ☐	2. DPT:	Yes ☑ / No ☐
3. BCG:	Yes ☑ / No ☐	4. Hepatitis B:	Yes ☐ / No ☐
5. Mumps, Measles, Rubella:	Yes ☐ / No ☑	6. Typhoid (above 1 Yr):	Yes ☐ / No ☑

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IRINE DIAGNOSTIC DELHI

7. Hepatitis A (Above 1 Yr) : Yes ☐ / No ☑			
D. Medical Examination			
Do you find any evidence of abnormality, disease or surgery of:			If yes please elaborate
1) the respiratory system?	☐ Yes	☑ No	
2) the central and peripheral nervous system?	☐ Yes	☑ No	
3) the genito urinary system?	☐ Yes	☑ No	
4) the abdominal organs?	☐ Yes	☑ No	
5) the head, face, mouth, throat, eyes, ears ,nose and neck?	☐ Yes	☑ No	
6) the skin, muscles, bones and joints?	☐ Yes	☑ No	
7) The Cardiovascular system:			
a) Are the peripheral pulses abnormal?	☐ Yes	☑ No	
b) Is there any evidence of heart enlargement?	☐ Yes	☑ No	
c) Are there murmurs or abnormal heart sounds?	☐ Yes	☑ No	
d) Do you suspect any abnormality of the cardiovascular system?	☐ Yes	☑ 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: _____ Name of the parent E.J. ALOK KUJUR
Mridula Rashmi Kindo

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 06 day of 10 2024 at 9:00 a.m./p.m.

ADVIKA JUDITH KUJUR

Signature / thumb impression
of the examinee

Dr. RAINA KHAN
MBBS, MD
Reg. No. 25503

Signature of the Medical Examiner
Name & Address
Qualification
Code:
Limit

IRINE DIAGNOSTICS DELHI

Confidential Comments from Doctor

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

- For physical investigations NIL
- For mental level assessment NIL

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अदविका जुडिथ कुजूर
Advika Judith Kujur
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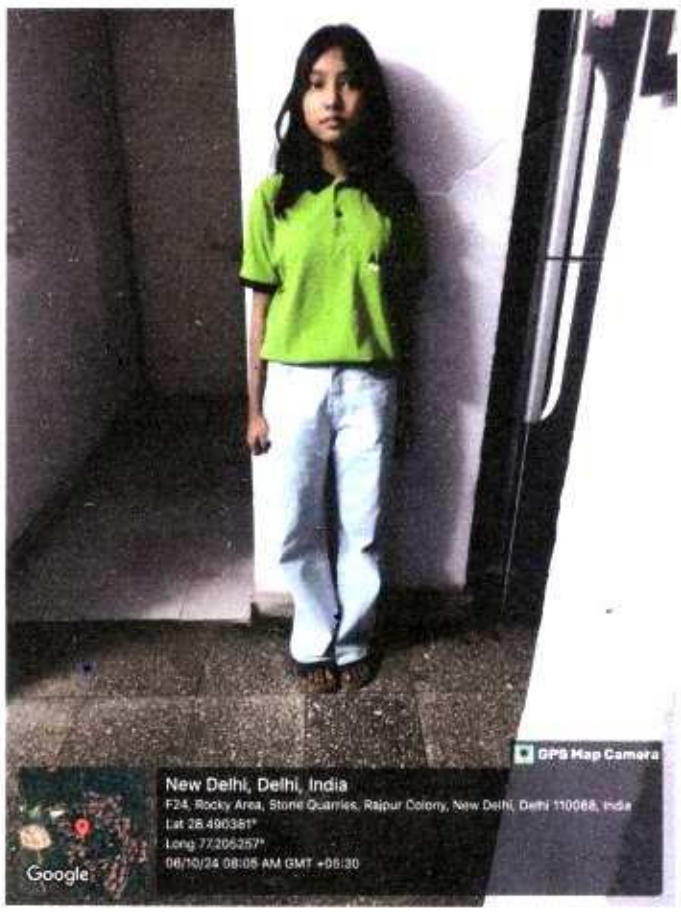
DR. RAINA KHAN
MBBS, DMRD
Reg. No. 25508



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