



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

Branch Code: _____
Proposal/ Policy No: 6158
MSP name/code : _____
Date & Time of Examination: 20/10/2024
Medical Diary No & Page No: _____

Mobile No of the Proposer/Life to be assured: _____
Identity Proof verified: UID ID Proof No. 7655
(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 (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: MR PUNEET KUMAR MAURYA
2 Date of Birth: 15/1990 Age: 34 Yr Gender: MALE
3 Height (In cms): 170 Weight (in kgs) : 79
4 Required only in case of Physical MER

Pulse : 76/M Blood Pressure (2 readings):
1. Systolic 129 Diastolic 80
2. Systolic 120 Diastolic 80

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 a. Whether receiving or ever received any **treatment/ medication** including alternate medicine like ayurveda, homeopathy etc ? No
b. Undergone any **surgery / hospitalized** for any medical condition / disability / injury due to accident? No
c. Whether visited the doctor any time in the last 5 years ? No
If answer to any of the questions 5(a) to (c)) is yes -
i. Date of surgery/accident/injury/hospitalisation
ii. Nature and cause
iii. Name of Medicine
iv. Degree of impairment if any
v. Whether unconscious due to accident, if yes, give duration
-No @ Eye removed due to accident at the age of 4 yrs (No visibility)

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	<p>a. Suffering from Hypertension (high blood pressure) or diabetes 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 endocrine disorders 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>No</p>
9	<p>a. Any history of chest pain, heartattack, palpitations and breathlessness on exertion or irregular heartbeat?</p> <p>b. Whether suffering from high cholesterol?</p> <p>c. Whether on medication for any heart ailment/ high cholesterol? Please state name of the prescribed medicine and dosage.</p> <p>d. Whether undergone Surgery such as CABG, open heart surgery or PTCA?</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p>
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 disorder like anaemia, 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 enlarged lymph nodes?	No
14	Suffering or ever 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	<p>a. Suffering from Depression/Stress/ Anxiety/ Psychosis or any other Mental / psychiatric disorder?</p> <p>b. Whether on treatment or ever taken any treatment, if yes, please give details of treatment, prescribed medicine and dosages</p>	<p>No</p> <p>No</p>
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 @ Eye removed due to accident of the eye of 4 yrs (no visibility)
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, gonorrhoea, 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



For Female Proponents only	
i.	Whether pregnant? If so duration.
ii	Suffering from any pregnancy related complications
iii	Whether consulted a gynaecologist or undergone any investigation, treatment for any gynaec ailment such as fibroid, cyst or any disease of the breasts, uterus, cervix or ovaries etc. or taken / taking any treatment for the same

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

You Mr/Ms Pooja Kaur Mangra 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.

Pooja Kaur

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 20 day of Oct 2024 vide Video call / Tele call/ Physical Examination personally and recorded true and correct findings to the aforesaid questions as ascertained from the life to be assured.

Dr. BINDU
MBBS, MD
Reg. No.-33435

Place: DELHI
Date: 20/10/2024

Signature of Medical Examiner
Name & Code No:
Stamp:





Life Insurance Corporation of India
(Established by the Life Insurance Corporation Act 1956)

Proposal No. 6158 Division _____

Full Name of the Life to be Assured Puneet Kumar MAURYA
(In Block Letters)

SPECIAL QUESTIONS IN RELATION TO THE EXAMINATION OF CENTRAL NERVOUS SYSTEM TO BE COMPLETE BY THE MEDICAL EXAMINER
(The Medical Examiner should give his remarks against each item mentioned below)

1. Headache :-	<u>No</u>	2. Memory :-	<u>Normal</u>
3. Temper :-	<u>Normal</u>	4. Speech :-	<u>Normal</u>
5. Sleep :-	<u>Normal</u>	6. Delusions :-	<u>Normal</u>
7. Fits, Faints, Giddiness :-	<u>No</u>	8. Ataxy :-	<u>No</u>
9. Nervousness :-	<u>No</u>	10. Tremors :-	<u>No</u>
11. Sight :-	<u>(R) Eye Normal (L) Eye</u>	12. Strabismus :-	<u>No</u>
13. Hearing :-	<u>Normal</u>	Tinnitus :-	<u>Normal</u>
14. Taste :-	<u>Good</u>	Ear Discharge :-	<u>No</u>
15. General Weakness :-	<u>No</u>		
16. Type of Paralysis :-	<u>No</u>		
	Upper Motor Neuron Type/Lower Motor Neuron Type		
17. Cramps :-	<u>No</u>		
18. Spinctors :-	(i) Rectal	<u>Normal</u>	
	(ii) Vesical	<u>Normal</u>	
19. Reflexes :-	Elbow, Wrist, Knee, Ankle planter Reflex	<u>Normal</u>	
20. Sensory Functions :-	<u>Normal</u>		
21. Motor System :-	(i) Involuntary movement	<u>Normal</u>	
	(ii) Atrophy or hypertrophy	<u>Normal</u>	
	(iii) Tone	<u>Normal</u>	
	(iv) Power	<u>Normal</u>	
	(v) Co-ordination	<u>Normal</u>	
22. Trophic Changes :-	<u>No</u>		
23. Posture & Gait :-	<u>Normal</u>		
24. General Remarks :-	<u>No</u>		

Dated at DELHI of the 20 day of oct 2004

Signature of the life to be Assured

Signature of the Medical Examiner
Qualifications :- _____

Corporation Code No. _____



Dr. BINDU
MBBS, MD
Reg. No.-33435



LIFE INSURANCE CORPORATION OF INDIA

Ophthalmic Report
[SHOULD BE OBTAINED FROM EYE SPECIALIST]

Branch Office _____ Agent's Name _____

Proposal No. 6158 Agent's Code No. _____

Name of the Life to be Assured : PUNEET KUMAR MAURYA

Age : 34 yrs

OPHTHALMIC REPORT

	Right Eye	Left Eye
1. What is the present visual occuity far and near, naked eye and with glasses	Without Glasses — With Glasses Eye removed.	Left Eye — with Glass (-0.1)
1A. (Power of Glasses)	N/A	(-0.1)
2. What is the nature of his refraction? Hypermetropia, Myopia etc.,	N/A	N/A
3. If myopia, how long he has been wearing Glasses? Is the Myopia progressive or stationary?	N/A	N/A
4. Describe the condition of media.	Eye removed.	Good
5. Has he any cataract? If so, which side? Is it mature or not? Whether operated or not?	-No-	-No-
6. Are iris and pupil normal? If not describe the abnormality. State pupillary reaction.	Eye removed.	Normal
7. Is there any squint? If so, paralytic or non-paralytic.	Eye removed	-No-
8. Did he have any ocular operation? If so, give details.	due to accident Eye removed	-No-
9. Is the fundus normal? If not, describe in detail the abnormality and its significance.	Eye removed.	Normal

10. Opinion Regarding vision: Present Position: (L) Eye vision Normal

Dated at DELHI on the 20 day of oct 20 24

<p>Signature of the Life to be Assured <u>[Signature]</u></p> <p>Signature of the Introducer: (Agent / Development Officer) Name : _____ Code No. _____</p>	<p>I Certify that the proposer / LA has put his /her Signature alongside in my presence</p> <p>Signature of the Ophthalmologist Name: <u>Dr. BINDU</u> Address: <u>[Signature]</u> Qualification: <u>MBBS, MD</u> Code No: <u>Reg. No.-33435</u></p>
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Division _____

Branch Office _____

DEFORMITY QUESTIONNAIREName of the proponent / Life Assured Puneet Kumar Mayya Age 34 Years

Questions to be answered by the proponent's / policyholder's Personal Medical Attendant / Medical Examiner regarding Deformity/ies and / or Impairment/s

1.	a. What is the cause of deformity? Whether it is i. Congenital ii. Due to an accident or injury ✓ iii. Due to any underlying disease?	R Eye removed due to accident no visibility @ Eye
	b. Since when the deformity is present?	30 yr BACK
2.	If the deformity is due to any underlying disease, please state the following: i. What was the disease leading to deformity? ii. When did it occur? iii. Whether the disease is stationery or progressive? iv. If stationery, since when	N/A
3.	Does he/she have control on bowel movements and bladder?	YES
4.	Exact parts of the body affected and extent	Right Eye
5.	Are there any restrictions in movements and function of the limbs or affected parts? Please give degree of disability	-No-
6.	Has he/she a limp?	-No-
7.	Whether he /she can walk and run fast without any aid (in case of deformity in the leg)?	YES
8.	Can he/she squat, sit and get up properly?	YES
9.	Whether the affected limb is shorter than the other , and if so, to what extent (in cms)	NO
10.	If the deformity is due to poliomyelitis, please state whether the wasting of muscles is i. mild ii. moderate iii. severe	N/A



11.	How many limbs are affected?	None
12	Are there any respiratory complications? If yes, give details	No
13	Is there any restriction in movement of any of the fingers? Are any of the fingers removed? If so, upto which phalanx. Whether thumb and forefinger have been affected / removed?	No
14	a. Whether he / she can lift articles without any difficulty and hold the articles without losing the grip (in case of deformity in the hands)? b. Is the grip firm and strong?	YES YES
15	Are there any residual complications?	No


My diagnosis as to the cause of the disability is None

I do for the reasons explained below / do not have any reason to suspect on clinical grounds a recent deterioration causing more pronounced disability:

- He / she is able / not able to perform routine self-care activities.
- He / she is / is not required to use wheel chair / crutches.
- Any other factors which are likely to add to the risk on account of the deformity / ies.

Please submit details of previous treatment, previous special reports, x-rays etc. for perusal and return.

Dated at DELHI on the 20 day of Oct 2024.


Signature of the proposer /
Policyholder



Dr. BINDU

MBBS, MD
Reg. No.-33435

Signature of the Medical Examiner /
Medical Attendant
Code No.
Qualifications
Registration No.
Address





भारत सरकार

Government of India



पुनीत कुमार मौर्य

Puneet Kumar Maurya

जन्म तिथि/DOB: 01/05/1990

पुरुष/ MALE




7456 1332 7655

VID : 9113 9824 4629 1803

मेरा आधार, मेरी पहचान

E ELITE
DIAGNOSTIC



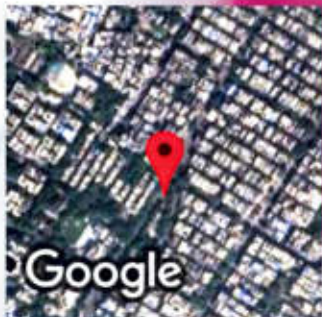
 **GPS Map Camera**

Delhi, Delhi, India

11886, Street 11, Nehru Nagar, Mata Rameshwari Nehru Nagar,
Karol Bagh, Delhi, 110005, India

Lat 28.648793° Long 77.182549°

20/10/24 09:40 AM GMT +05:30



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