

# 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) <u>ADVIKA JUDITH KUSUR</u>				
Mark of identification: Mole/Scar/any other (specify location) <u>NO</u>				
Current ID provided	Student	Passport	Latest School Report Card	Others(specify) <u>UID-4171</u>
Age of the child: <u>17</u> Years/Months <u>09</u>		SEX: M <input type="checkbox"/> / F <input checked="" type="checkbox"/>		
Birth History: FTND / Forceps / Caesarean/ Other ( Please tick the relevant) <u>Normal</u>				
<b>A. Details of Physical Examination</b>				
For all children:				
Height of the child: <u>157</u> cms		Weight of the child: <u>45</u> kgs		
Pulse and character <u>90/4</u>		Blood Pressure <u>110/76</u> mm of Hg		
Presence of any congenital defects or abnormalities: Yes / <u>No</u> ( If yes, please provide details)				
For Children Below 2 yrs:				
Head Circumference <u>53</u> cms		Chest Circumference <u>80</u> cms		
<b>B. Medical History:</b>				
1) Is the proposed insured presently in good health?			Yes <input checked="" 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 no 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: Mother : Sibling 1 Sibling 2 <u>NO</u>	
<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 type="checkbox"/> / No <input checked="" type="checkbox"/>		
5. Mumps, Measles, Rubella: Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>		6. Typhoid (above 1 Yr): Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>		

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7. Hepatitis A ( Above 1 Yr): Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>		
<b>D. Medical Examination</b>		
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 abnormal?	<input type="checkbox"/> Yes <input checked="" 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: [Signature] Name of the parent E. J. ALOK Kujur  
Mridula Rashmi Kundo

**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.

ADVIRA JUDITH Kujur

Signature / thumb impression  
of the examinee

Dr. RAINA KHAN

MBBS  
Reg. No. 25503

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 NO
- For mental level assessment NO





आपका आधार क्रमांक / Your Aadhaar No.

**4171**

मेरा आधार, मेरी पहचान

भारत सरकार  
Government of India

अदविका जुद्धि कुजर  
Advika Juddh Kujur  
जन्म तिथि / DOB 04/01/2007  
लिंग / Female

4171

मेरा आधार, मेरी पहचान

Unauthorized release return to: पी.ओ. बंगलूर - 560 004  
P.O. Bux No. 1947, Bengaluru - 560 004

आपका आधार क्रमांक / Your Aadhaar No.

**7852**

मेरा आधार, मेरी पहचान

भारत सरकार  
Government of India

मदुला रश्मि किशोर  
Madula Rashmi Kishor  
जन्म तिथि / DOB 14/04/2005  
लिंग / Female

7852

मेरा आधार, मेरी पहचान

Unauthorized release return to: पी.ओ. बंगलूर - 560 004  
P.O. Bux No. 1947, Bengaluru - 560 004



DR. RAJESH KHAN  
M.D. DIMRD  
Reg. No. 25508

