WILLING MEDICAL EXAMINER'S REPORT Form No LIC03-001 (Revised 2020) MSP name/code : Mobile No of the Proposer/Life to be assured: MSP name/code : Date 3 Time of Examination: Zet 1 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 /			Branch Code:				
Form No LLC03-001 (Revised 2020) MSP name/code : Date& Time of Examination: 3/2 (10) 3/2/4 Mobile No of the Proposer/Life to be assured: UP to the Proposer/Life to be assured: UP to 10 Proof No. (In Case of Aadhaar Card , please mention only last four digits) INder No of the Proposer/Life to be assured: UP to the No of the Proposer/Life to be assured: UP to 10 Proof No. (In Case of Aadhaar Card , please mention only last four digits) INder No of the Proposer/Life to be assured: UP to the No of the Proposer/Life to be assured: UP to the No of the Proposer/Life to be assured: (In Case of Aadhaar Card , please mention only last four digits) INder No of the Proposer/Life to be assured: (In Case of Aadhaar Card , please mention only last four digits) To Tele/ Video MER, consent given below is to be recorded either through email or audioVideo 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	10:0						
Initial statistic Date 3 Time of Examination: 32 to 324 to 3244 Mobile No of the Proposer/Life to be assured: U.C. ID Proof No. 1121 Identity Proof verified: U.C. ID Proof No. 1121 (In Case of Aadhaar Card , please mention only last four digits) INote: Mobile number and Identity proof details to be filled in above . For Physical MER, Identity 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 on behalf of LIG of India "I would like to inform that this call with visit to Dr	(man)						
Medical Diary No & Page No: Mobile No of the Proposer/Life to be assured: U ID ID Proof No. II [1] In Clease of Aachaar Card , please mention only last four digits] Interview of the proposer/Life to be assured: Interview of the proposer/Life to be assured: In Clease of Aachaar Card , please mention only last four digits] Interview of the proposer/Life to be assured: Interview of the proposer/Life to be assured: In Clease of Aachaar Card , please mention only last four digits] Interview of the mention of Life to be assured: Interview of the Medical Examination on behalt of LIC of India I' would like to inform that this call with/visit to Dr	भारतीय						
Mobile No of the Proposer/Life to be assured: ID Proof No. [1:2] (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/ViceO 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 Examination on behalf of LC of India Signature/ Thumb impression of Life to be assured (In case of Physical Examination) (Name of the Medical Examination on behalf of LC of India 1 Full name of the life to be assured: M. MTLAMTAM MUKHERTEE 2 Date of Birth: 1/1/2/1983 Age: Yes Gender: 4 Required only in case of Physical MER Plastolic So Pulse: Blood Pressure (2 readings): 1. Systolic So 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// medication reports, histopathology report. 5 a. Whether receiving or ever received any treatment// medication received any treatment// Mor 1 Fuls number and the list Sy	The mestine	NCE CORPORATION OF INDEA	Medical Diary No & Page No:				
Identity Proof verified: UPC ID Proof No. [[17] (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. [Port Jele/ Video MER, consent given below is to be recorded either through email or audio/video "I would like to inform that this call with/ visit to Dr	Mot	bile No of the Proposer/Life to be assured:	Modical Plat file a suggestion				
(In Case of Aadhaar Card, please mention only last four digits) I 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/Viceo 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 "I would like to inform that this call with/ visit to Dr With the to inform that this call with/ visit to Dr "I would like to inform that this call with/ visit to Dr "I would like to inform that this call with/ visit to Dr "I would name of the life to be assured (In case of Physical Examination) I Full name of the life to be assured: I Full name of the life to be assured: I height (In cms): I + I I height (In cms): I + Required only in case of Physical MER Puise : Blood Pressure (2 readings): I + Systolic J + Meight (In cms): I + Required only in case of Physical Itrastment papers, investigation reports, histopathology report. distarge card, follow up reports etc. along with the proposal torm to the Corporation 5 a. Whether receiving or ever received any treatment// <t< td=""><td>Ider</td><td>ntity Proof verified: ULD ID P</td><td>roof No. 1171</td></t<>	Ider	ntity Proof verified: ULD ID P	roof No. 1171				
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							
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							
For TeleY Video MER, consent given below is to be recorded either through email or audiovideo 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	Pro	of is to be verified and stamped 1					
message. For Physical Examination the below consent is to be obtained before examination. (Name of the 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) (Name of the life to be assured (In case of Physical Examination) 1 Full name of the life to be assured: N.M. N.T.LAM.TAM. MUKHERSTER 2 Date of Birth: 1/2/1983 Age: York 3 Height (In cms): 1.3. Weight (In kgs): 2.2.3 4 Required only in case of Physical MER Blood Pressure (2 readings): 1. Systolic Las Diastolic 9 Uilse: Blood Pressure (2 readings): 1. Systolic Las Diastolic 86 2 Systolic Lasson 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/ medical on including alternate medicine like ayureda, homeopathy etc ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? Nomeof surger/gradedetione like ayureda, homeopathy etc ? i. Nature and cause ii. Name of surger/gradedetion like divedical surger Nomeof surger/gradedetion ii. Name of surger/	For	Tele/ Video MER, consent given below is to be rec	corded either through email or audio/video				
"I would like to inform that this call with/ visit to Dr (Name of the 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) Full name of the life to be assured: 1 Full name of the life to be assured: M. MILANTAM MUKHERITER 2 Date of Birth: 1/2/1983 [Age: 4 to Yrx Gender: 3 Height (In cms): 1.3 Ysta Gender: MALE 4 Required only in case of Physical MER Blood Pressure (2 readings): 1.5 Systolic 2.2 4 Required only in case of Physical MER Blood Pressure (2 readings): 1.5 1.5 Systolic 2.6 2 Systolic L20 Diastolic 80 2.5 2.5 Systolic 80 2.5 7 Blood Pressure (2 readings): 1.5 Systolic 80 2.5 Diastolic 80 2.5 8 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/	mes	sage. For Physical Examination the below consen	t is to be obtained before examination.				
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: 2 Date of Birth: 1//2/1983 Age: 4/0 Yrz Gender: MALE 3 Height (In cms): 1.1 Weight (in kgs): 8/2-3 4 Required only in case of Physical MER Pulse : Blood Pressure (2 readings): 1. Systolic 1/2 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 pagers, 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause iii. Nature and cause of undergo an X-ray/ CT scan / MRI / ECG / TMT / Blood test / Sputum/Throat swab test or any other investigatory or diagnostic tests? 7 Suffering or ever suffered from Novel Coronavirus (Covid-19) or experienced any of the symptoms such as nausea, vomiting and/or diarhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days.			22				
Signature/ Thumb impression of Life to be assured (In case of Physical Examination) If an arm of the life to be assured: In Case of Physical Examination) Image: The second se	"I W	ould like to inform that this call with/ visit to Dr	(Name of the Medical				
Signature/ Toumb impression of Life to be assured (In case of Physical Examination) In the life to be assured: Image: Annothee im	Exa	miner) is for conducting your Medical Examination	through Tele/ Video/ Physical Examination on				
(In case of Physical Examination) 1 Full name of the life to be assured: M.J.J.A.J.TAW. MWK.HIKATEK 2 Date of Birth: / //2/1983 Age: 4 or yrs. Gender: MALE 2 Date of Birth: / //2/1983 Age: 4 or yrs. Gender: MALE 3 Height (In cms): 1. Weight (in kgs): 82-3 4 Required only in case of Physical MER Diastolic 86 2. Systolic 2.2 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause ii. Nature and cause ii. Name of Medicine iv. Whether unconsclous due to accident, if y	Den	an of Lic of India					
(In case of Physical Examination) 1 Full name of the life to be assured: M.J.J.A.J.TAW. MWK.HIKATEK 2 Date of Birth: / //2/1983 Age: 4 or yrs. Gender: MALE 2 Date of Birth: / //2/1983 Age: 4 or yrs. Gender: MALE 3 Height (In cms): 1. Weight (in kgs): 82-3 4 Required only in case of Physical MER Diastolic 86 2. Systolic 2.2 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause ii. Nature and cause ii. Name of Medicine iv. Whether unconsclous due to accident, if y							
(In case of Physical Examination) 1 Full name of the life to be assured: M.J.J.A.J.TAW. MWK.HIKATEK 2 Date of Birth: / //2/1983 Age: 4 or yrs. Gender: MALE 2 Date of Birth: / //2/1983 Age: 4 or yrs. Gender: MALE 3 Height (In cms): 1. Weight (in kgs): 82-3 4 Required only in case of Physical MER Diastolic 86 2. Systolic 2.2 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause ii. Nature and cause ii. Name of Medicine iv. Whether unconsclous due to accident, if y	Sigr	nature/ Thumb impression of Life to be assured					
1 Full name of the life to be assured: M. IILANTAN MUKHERTER 2 Date of Birh: III/J1983 Age: Yrx Gender: MALE 3 Height (In cms): 1.4 Weight (in kgs): S2-3 4 Required only in case of Physical MER Biood Pressure (2 readings): 1. Systolic Jastolic S0 2 Systolic Jazo Diastolic S0 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? . 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 - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause iii. Name of Medicine Youther hore conscious due to accident, if yes, give duration 6 in the last 5 years. if advised to undergo an X-ray/ CT scan / MRI/ Blod test ? Mor Please specify da		(In case of Physical Examination)					
2 Date of Birth: ///2/198/3 Age: 4/0 Yr/2 Gender: MALE 3 Height (in cms): 1/2 Weight (in kgs): 2/2 Gender: MALE 4 Required only in case of Physical MER Blood Pressure (2 readings): 1. Systolic 1/2/2 Diastolic 8/0 2 Systolic 1/2/2 Diastolic 8/0 2. Systolic 1/2/2 Diastolic 8/0 4 Required only in case of Physical MER Diastolic 8/0 2. Systolic 1/2/2 Diastolic 8/0 4 Recurred 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 3. Whether receiving or ever received any treatment/ 6 a. Whether receiving or ever received any treatment in the last 5 years ? if answer to any of the questions 5(a) to (c) is yes - 1 i. Date of surgery/acident/injury/hospitalisation ii. Nature and cause iii. Nature and cause iii. Nature and cause iii. Nature and cause iii. Nature of Medicine v. Whether unconscious due to accident, if yes, give duration Mor 7 Suffering or ever suffered from Novel Coronavirus (Covid-19) Mor 7 Suffering or ever suffered from Novel Coronavirus (Covid-19) Mor 7 Suffering or ever suffered from Novel Coronavirus	1		NITIANJAN MUKHIRZJER				
 Height (In cms): 12.1 Weight (in kgs): 8.2-3 Required only in case of Physical MER Pulse: Blood Pressure (2 readings): Systolic 1.2.2 Diastolic 8.6 Systolic 1.2.2 Diastolic 8.6 Systolic 1.2.2 Diastolic 8.6 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 a. Whether receiving or ever received any <i>treatment/</i> medication including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - 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 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 dlagnostic tests? Please specify date , reason, advised by whom & findings. 7 Suffering or ever suffered from Novel Coronavirus (Covid-19) or experienced any of the symptoms such as anusea, vomiting and/or diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days. A. Marce	2						
4 Required only in case of Physical MER Pulse : Blood Pressure (2 readings): 1. Systolic Diastolic 2. Systolic Diastolic 30 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Name of Medicine iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration 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 dlagnostic tests? Please specify date , reason, advised by whom & findings. 7 Suffering or ever suffered from Novel Coronavirus (Covid-19) or experienced any of the symptoms such as nausea, vomiting and/or diarrhoea, Chills,							
Pulse: Blood Pressure (2 readings): 1. Systolic 2. Diastolic 86 1. Systolic 2. Systolic 2. Systolic 2. Systolic 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 <i>treatment/</i> medication including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - 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 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. 7 Suffering or ever suffered from Novel Coronavirus (Covid-19) or experien	4						
G8/M 1. Systolic 1/2/2 Diastolic 86 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause iii. Nature and cause iii. Name of Medicine MRI / ECG / TMT / Blood test / Sputum/Throat swab test or any other investigatory or dlagnostic tests? Please specify date , reason , advised by whom & findings. MRI / ECG / TMT / Blood test / Sputum/Throat swab test or any other investigatory of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flullike tiredness), Rhinorrhea (mucus discharge from the nose), Sore throat, Gastro-intestinal symptoms such as nausea, vormiting and/or diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days.	-	Pulse : Blood Pressure (2 readings):				
2. Systolic Justolic So 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 ? b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? o 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 - i. Date of surgery/accident/injury/hospitalisation ii. Name of Medicine iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration O 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 dlagnostic tests? O Please specify date . reason ,advised by whom &findings. O O 7 Suffering or ever suffered from Novel Coronavirus (Covid-19) or experienced any five symptoms such as nausea, vomiting and/or diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 davs. O			2 Diastolic 86				
 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 a. Whether receiving or ever received any <i>treatment/</i> <i>medication</i> including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any <i>surgery / hospitalized</i> for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Nature and cause iii. Nature and cause iii. Name of Medicine iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration 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 <i>dlagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malalse (Ilulike 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. 		2. Systolic /	20 Diastolic 80				
 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 a. Whether receiving or ever received any <i>treatment/</i> <i>medication</i> including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any <i>surgery / hospitalized</i> for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Name of Medicine iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration 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 <i>diagnostic tests</i>? Please specify date , reason, advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flullike 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. 		ASCERTAIN THE FOLLOWING FROM THE PER	RSON BEING EXAMINED				
 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 a. Whether receiving or ever received any <i>treatment/</i> <i>medication</i> including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any <i>surgery / hospitalized</i> for any medical condition / disability / injury due to accident? 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 - i. Date of surgery/accident/injury/hospitalisation ii. Name of Medicine iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration 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 <i>diagnostic tests</i>? Please specify date , reason, advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flullike 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. 			- stars size full datally and call life to be				
 discharge card, follow up reports etc. along with the proposal form to the Corporation a. Whether receiving or ever received any <i>treatment/</i> <i>medication</i> including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any <i>surgery / hospitalized</i> for any medical condition / disability / injury due to accident? 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 - 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 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 <i>diagnostic tests</i>? Please specify date , reason , advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malalse (flulike 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 answer/s to any of the following questions is Ye	is, please give full details and ask life to be				
 a. Whether receiving or ever received any <i>treatment/</i> <i>medication</i> including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any <i>surgery / hospitalized</i> for any medical condition / disability / injury due to accident? 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 - Date of surgery/accident/injury/hospitalisation Nature and cause Name of Medicine Degree of impairment if any Whether unconscious due to accident, if yes, give duration 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 <i>dlagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> 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. 							
 <i>medication</i> including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any <i>surgery / hospitalized</i> for any medical condition / disability / injury due to accident? 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 - Date of surgery/accident/injury/hospitalisation Nature and cause Name of Medicine V. Whether unconscious due to accident, if yes, give duration 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 <i>diagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flullike tiredness), Rhinorrhea (mucus discharge from the nose), Sore throat, Gastro-intestinal symptoms such as nausea, vomiting and/or diarnboea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days. 	5	a. Whether receiving or ever received any treatm	ent/				
 b. Undergone any surgery / hospitalized for any medical condition / disability / injury due to accident? 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 - 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 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. 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 (flulike 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. 							
 condition / disability / injury due to accident? 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 - Date of surgery/accident/injury/hospitalisation Nature and cause Name of Medicine Negree of impairment if any Whether unconscious due to accident, if yes, give duration 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 <i>dlagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flullike tredness), 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.							
 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 - 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 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 <i>dlagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flullike 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. 			medical				
 i. Date of surgery/accident/injury/hospitalisation Nature and cause Nature and cause Name of Medicine Degree of impairment if any Whether unconscious due to accident, if yes, give duration 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 <i>diagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> 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.			Evente 2				
 i. Date of surgery/accident/injury/hospitalisation Nature and cause Nature and cause Name of Medicine Degree of impairment if any Whether unconscious due to accident, if yes, give duration 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 <i>diagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> 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.							
 ii. Nature and cause iii. Name of Medicine iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration 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 <i>dlagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> 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. 							
 iv. Degree of impairment if any v. Whether unconscious due to accident, if yes, give duration 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 <i>dlagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flulike 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. 							
 v. Whether unconscious due to accident, if yes, give duration 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 <i>dlagnostic tests</i>? Please specify date , reason ,advised by whom &findings. Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> 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. 		iii. Name of Medicine					
 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 <i>diagnostic tests</i>? Please specify date, reason, advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> 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. 							
 MRI / ECG / TMT / Blood test / Sputum/Throat swab test or any other investigatory or <i>diagnostic tests</i>? Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flulike 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. 							
other investigatory or diagnostic tests?	6						
 Please specify date , reason ,advised by whom &findings. 7 Suffering or ever suffered from <i>Novel Coronavirus (Covid-19)</i> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flulike 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. 		MRI/ECG/IMI/Blood test/Sputum/Inroat sw	ab test or any				
 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 (flulike 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. 							
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.	7						
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.	1	or experienced any of the symptoms (for more the	in 5 days)				
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.		such as any fever, Cough, Shortness of breath M	alaise (flu-				
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.		like tiredness). Rhinorrhea (mucus discharge from	the nose).				
vomiting and/or diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days.		Sore throat, Gastro-intestinal symptoms such as n	ausea,No-				
Muscle pain, Headache, Loss of taste or smell within last 14 days.		vomiting and/or diarrhoea, Chills, Repeated shaking	ng with chills,				
days. If ves provide all investigation and treatment reports		Muscle pain, Headache, Loss of taste or smell within last 14					
If ves provide all investigation and treatment reports		Muscie pain, meadache, coso or laste or oritor mit					
		days.					



1	a. Suffering from <i>Hypertension</i> (high blood pressure) or diabetes or blood sugar levels higher than normal or history	1
	of sugar /albumin in urine?	
	b. Since when, any follow up and date and value of last	
	checked blood pressure and sugar levels?	rt°
	c. Whether on medication? please give name of the prescribed	F
	medicine and dosage	
	d. Whether developed any complications due to diabetes? e. Whether suffering from any other endocrine disorders such	
	e. Whether suffering from any other endocrine discrete cost	/
	as thyroid disorder etc.? f. Any weight gain or weight loss in last 12 months (other than	
	by diet control or exercise)?	
•	a. Any history of chest pain, <i>heartattack</i> , palpitations and	
	breathlessness on exertion or irregular heartbeat?	
	b. Whether suffering from high cholesterol?	
	 Whetheron medication for any heart ailment/ high 	
	cholesterol? Please state name of the prescribed medicine	~H°
	and dosade	
	d. Whether undergone Surgery such as CABG, open heart	/
	surgery or PTCA?	
10	Suffering or ever suffered from any disease related to kidney	-Nor
	such as kidney failure, kidney or ureteral stones, blood of pus	- 14- /
	in urine or prostate?	
11	Suffering or ever suffered from any Liver disorders like	-No.
	cirrhosis, hepatitis, jaundice, or disorder of the Spleen or from	-140:
	any <i>lung related</i> or respiratory disorders such as Asthma,	
	bronchitis, wheezing, tuberculosis breathing difficulties etc.?	a Area
12	Suffering or ever suffered from any <i>Blood disorder</i> like	-No-
	anaemia, thalassemia or any Circulatory disorder? Suffering or ever suffered from any form of <i>cancer</i> , leukaemia,	-Mo -
13	tumor, cyst or growth of any kind or enlarged lymph nodes?	
	Cuttoring or over suffered from Epilepsy, nervous disorder,	-100 -
14	multiple eclerosis tremors, numbress, paralysis, brain stroke:	- 143
15	Suffering or over suffered from any Drysical Impairment	
15	disability /amoutation or any congenital disease/aphormality of	- No-
	disorder of back neck muscle, joints, bones, annitis of gout:	
16	Outtoring or over suffered from Hernia or disorder of the	No-
	Stomach / intestines, colitis, indigestion, Peplic ulcer, plies, or	400-
	the disease of the gall bladder of ballcieds:	
17	a Suffering from Depression/Stress/ Anxiety/ Psychosis of any	
1.	the state of a perception of the state of th	10
	I whather on treatment or ever taken any freditient, if yes,	-M-
	please give details of treatment, prescribed medicine and	/
	1	
18	Is there any abnormality of Eyes (partial/total blindness),Ears	100
	(deafness/ discharge from the ears), Nose, Throat or Mouth,teeth, swelling of gums / tongue, tobacco stains or signs	- 210-
	of oral cancer? Whether person being examined and/ or his/her spouse/partner	
19	Whether person being examined and of marter spouse particle	
	tested positive or is/ are under treatment for <i>HIV</i> / <i>AIDS</i> / <i>Sexually transmitted diseases</i> (e.g. syphilis,	-No-
	AIDS Sexually transmitted diseases (e.g. systimo,	
	gonorrhea, etc.) Ascertain if any other condition / disease / adverse habit (such	
	Ascentain it any other condition / disease / adverse mabit (such	
2	amaking/tobacco.chewing/consilmotion.ol	
2	as <i>smoking/ tobacco chewing/ consumption of</i> <i>alcohol/drugs</i> etc) which is relevant in assessment of medical	-No-



ANNEXURE II - 1

LIFE INSURANCE CORPORATION OF INDIA

Form No. LIC03 - 002

ELECTROCARDIOGRAM

Zone Division Branch Proposal No. -6466 Agent/D.O. Code: Introduced by: (name & signature) Full Name of Life to be assured: MR. MIILANJAN MUK HERJEE Age/Sex HOM Instructions to the Cardiologist:

- i. Please satisfy yourself about the identity of the examiners to guard against impersonation
- The examinee and the person introducing him must sign in your presence. Do ii. 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 T wave change, they should be recorded additionally in deep inspiration. If V1 shows a tall R-Wave, additional lead V4R 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 the proposal dated _____ given by me to LIC of India.

Witness

Signature or Thumb Impression of L.A.

- Note: Cardiologist is requested to explain following questions to L.A. and to note the answers thereof.
 - i. Have you ever had chest pain, palpitation, breathlessness at rest or exertion? Y/N
 - Are you suffering from heart disease, diabetes, high or low Blood Pressure or ii. kidney disease? Y/N
 - Have you ever had Chest X- Ray, ECG, Blood Sugar, Cholesterol or any other iii. test done? Y/N

If the answer/s to any/all above questions is 'Yes', submit all relevant papers with this form.

Dated at DECHT on the day of 28/oct/2022Signature of the Cardiologist

Signature of L.A.

Name & Address Qualification Code No.





Clinical findings

(A)

Height (Cm)	Weight (kgs)	Blood Pressure	Pulse Rate
172	8.97	122 80	rola

(B) Cardiovascular System

Rest ECG Report:

Position	Sydine	P Wave	60
Standardisation Imv	R	PR Interval	RO
Mechanism	(A)	QRS Complexes	R
Voltage	G	Q-T Duration	(N)
Electrical Axis	N N	S-T Segment	(R)
Auricular Rate	68/2	T -wave	(N)
Ventricular Rate	68/M	Q-Wave	(N)
Rhythm	0		
Additional findings, if any	Repula		

......

Conclusion: ECG- WNL

Dated at Dechr on the day of 28 oct 2094

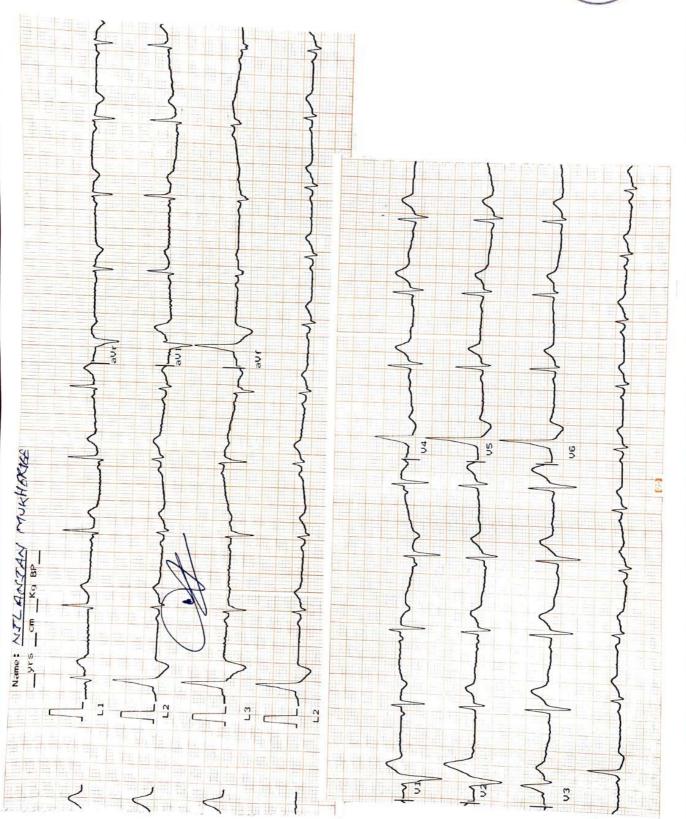
Signature of the Cardiologist Name & Address Qualification Code No.







EN





Email - elitediagnostic4@gmail.com

S. NO. NAME : REF. BY : Date : <u>HAEMOGRAM</u>	6466 110260 MR. NILANJAN M LIC OCTOBER,28,202		AGE	C/SEX - 40/M
Test Hemoglobin		Result	Units	Normal Range
		14.12	gm/dl	12-18
BIOCHEMISTRY-(SBT-13)				
Blood Sugar Fasting S. Cholesterol H.D.L. Cholesterol L.D.L. Cholesterol S.Triglycerides S.Creatinine Blood Urea Nitrogen (Albumin Globulin S.Protein Total AG/Ratio Direct Bilirubin Indirect Bilirubin Total Bilirubin S.G.O.T. S.G.P.T. Gamma Glutamyl Transf S. Alk. Phosphatase		92.47 168.17 70.48 115.40 98.39 0.90 12.32 4.1 2.9 7.0 1.50 0.2 0.6 0.8 29.17 30.82 40.40 46.85	mg/dl mg/dl mg/dl mg/dl mg/dl mg/dl gm% gm% gm% gm% mg/dl mg/dl ng/dl IU/L IU/L IU/L	70-115 130-250 35-90 0-160 35-160 0.5-1.5 06-21 3.2-5.50 2.00-4.00 6.00-8.5 0.5-3.2 0.00-0.3 0.1-1.00 0.1-1.3 00-42 00-42 00-60 28-111
(EDOLOGY			(Ch	ildren 151- 471)

SEROLOGY

Test Name : Human Immun		unodeficiency Virus I&II {HIV}(Elisa method)		
Result	· · · · ·	"Non-Reactive"		

	•	Non-Reactive"
Normal-Range	:	"Non-Reactive"

Test Name	:Hepatitis B Surface Antigen {HbsAg}} (Elisa method)
D	

Result	:	"Non-Reactive"
Normal-Range	:	"Non-Reactive"

********End of The Report********

Please correlate with clinical conditions.

DR. T.K. MATHUR M.B.B.S. MD (PATH) REGD.NO. 19702

7091, Gali no. 10, Mata Rameshwari Marg, Nehru Nagar Karol Bagh, Delhi-CHORS & Integration 1-265(0) 2021 - 265(0)



Email – elitediagnostic4@gmail.com

PROP. NO.	:	6466	
S. NO.	:	110260	
NAME	:	MR. NILANJAN MUKHERJEE	AGE/SEX - 40/M
REF. BY	:	LIC	
Date	:	OCTOBER, 28, 2024	

ROUTINE URINE ANALYSIS

PHYSICAL EXAMINATION

Quantity	:	20.ml
Colour		P.YELLOW
Transparency	:	Clear
Sp Gravity	:	1.014

CHEMICAL EXAMINATION

Reaction	:	ACIDIC	
Albumin	:	Nil	/HPF
Reducing Sugar	:	Nil.	/HPF
MICROSCOPIC EXAMINATION			

Pus Cells/WBCs		1-2.	/HPF
RBCs	:	Nil.	/HPF
Epithelial Cells	:	1-2.	/HPF
Casts	:	Nil.	
Crystals	:	Nil.	/HPF
Bacteria	:	Nil.	
Others		Nil.	

*********End of The Report *********

Please correlate with clinical conditions.

DR. T.K. M.	ATH.	UR
M.B.B.S.		
REGD.NO.	197	702
REGD.NO.	nt I	Pathologist

7091, Gali no. 10, Mata Rameshwari Marg, Nehru Nagar Karol Bagh, Delhi- 110005 Contact: +91-9650089041, 9871144570 NOTE : Not to the final Diagnosis if highly abnormal or do not correlate clinically. Please refer to the lab without any <u>hasitation. This report is not for</u> <u>mediço - legal cases.</u>

Fo	r Female Proponents only	
i.	Whether pregnant? If so duration.	/
Î	Suffering from any pregnancy related complications	. /
11	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	HA

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

Declaration

You Mr/Ms <u>Mixauca</u> <u>Mukauca</u> 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.

YES

Signature/ Thumb implession 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 ____day of ______ 20_____ 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.

Place: 12 CHY Date: 28/10/2024

Signature of Medical Examiner Name & Code No: Stamp:

Dr









नीलांजन मुखार्जी Nilanjan Mukherjee जन्म तिथि / DOB : 01/12/1983 पुरुष / Male

भारत सरकार

Government of India

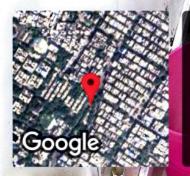


आधार पहचान का प्रमाण है, नागरिकता का नहीं। Aadhaar is a proof of identity, not of citizenship.

9341 2068 1171

मेरा आधार, मेरी पहचान

🧕 GPS Map Camera



Delhi, Delhi, India 11886, Street 11, Nehru Nagar, Mata Rameshwari Nehru Nagar, Karol Bagh, Delhi, 110005, India Lat 28.64877° Long 77.182534° 28/10/24 09:27 AM GMT +05:30

ELITE DIAGNOSTIC