भारतीय जीवन बीमा निगम
LIFE INSURANCE CORPORATION OF INDIA

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

Branch Code:	
Proposal/ Policy No:	6466
MSP name/code :	
Date& Time of Examination:	28/10/2024
Medical Diary No & Page No:	

Mobile No of the Proposer/Life to be assured: _____
Identity Proof verified: UID ID Proof No. 1171
(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. NILANJAN MUKHERJEE			
2	Date of Birth: 1/12/1983	Age: 40 Yrs	Gender:	MALE
3	Height (In cms): 172	Weight (in kgs) : 82-3		
4	Required only in case of Physical MER			
	Pulse : 68/M	Blood Pressure (2 readings): 1. Systolic 122 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 ? 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			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

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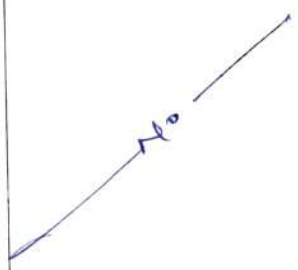
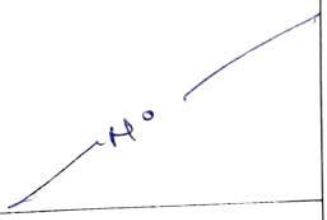
8	a. Suffering from ***Hypertension*** (high blood pressure) or ***diabetes*** or blood sugar levels higher than normal or history of sugar /albumin in urine? b. Since when, any follow up and date and value of last checked blood pressure and sugar levels? c. Whether on medication? please give name of the prescribed medicine and dosage d. Whether developed any complications due to diabetes? e. Whether suffering from any other ***endocrine disorders*** such as thyroid disorder etc.? f. Any weight gain or weight loss in last 12 months (other than by diet control or exercise)?	
9	a. Any history of chest pain, ***heartattack***, palpitations and breathlessness on exertion or irregular heartbeat? b. Whether suffering from ***high cholesterol*** ? c. Whetheron 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?	
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	a. Suffering from Depression/Stress/ Anxiety/ Psychosis or any other Mental / ***psychiatric disorder***? b. Whether on treatment or ever taken any treatment, if yes, please give details of treatment, prescribed medicine and dosages	
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-

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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. NILANJAN MUKHERJEE

Age/Sex : 40/M

Instructions to the Cardiologist:

i. Please satisfy yourself about the identity of the examiners to guard against impersonation

ii. The examinee and the person introducing him must sign in your presence. Do 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.

ii. Are you suffering from heart disease, diabetes, high or low Blood Pressure or kidney disease? Y/N.

iii. Have you ever had Chest X- Ray, ECG, Blood Sugar, Cholesterol or any other test done? Y/N.

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

Dated at DELHI on the day of 28/oct/2021

Signature of L.A.

Signature of the Cardiologist
Name & Address
Qualification Code No.

ELITE HEALTH CENTER DELHI

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

Clinical findings

(A)

Height (Cm)	Weight (kgs)	Blood Pressure	Pulse Rate
172	82.3	122/80	68/M

(B) Cardiovascular System

..... (N) .....

.....

Rest ECG Report:

Position	Supine	P Wave	(N)
Standardisation Imv	(N)	PR Interval	(N)
Mechanism	(N)	QRS Complexes	(N)
Voltage	(N)	Q-T Duration	(N)
Electrical Axis	(N)	S-T Segment	(N)
Auricular Rate	68/M	T –wave	(N)
Ventricular Rate	68/M	Q-Wave	(N)
Rhythm	Regular		
Additional findings, if any	NAD		

Conclusion: ECG- WNL

Dated at DELHI on the day of 28/oct/2024

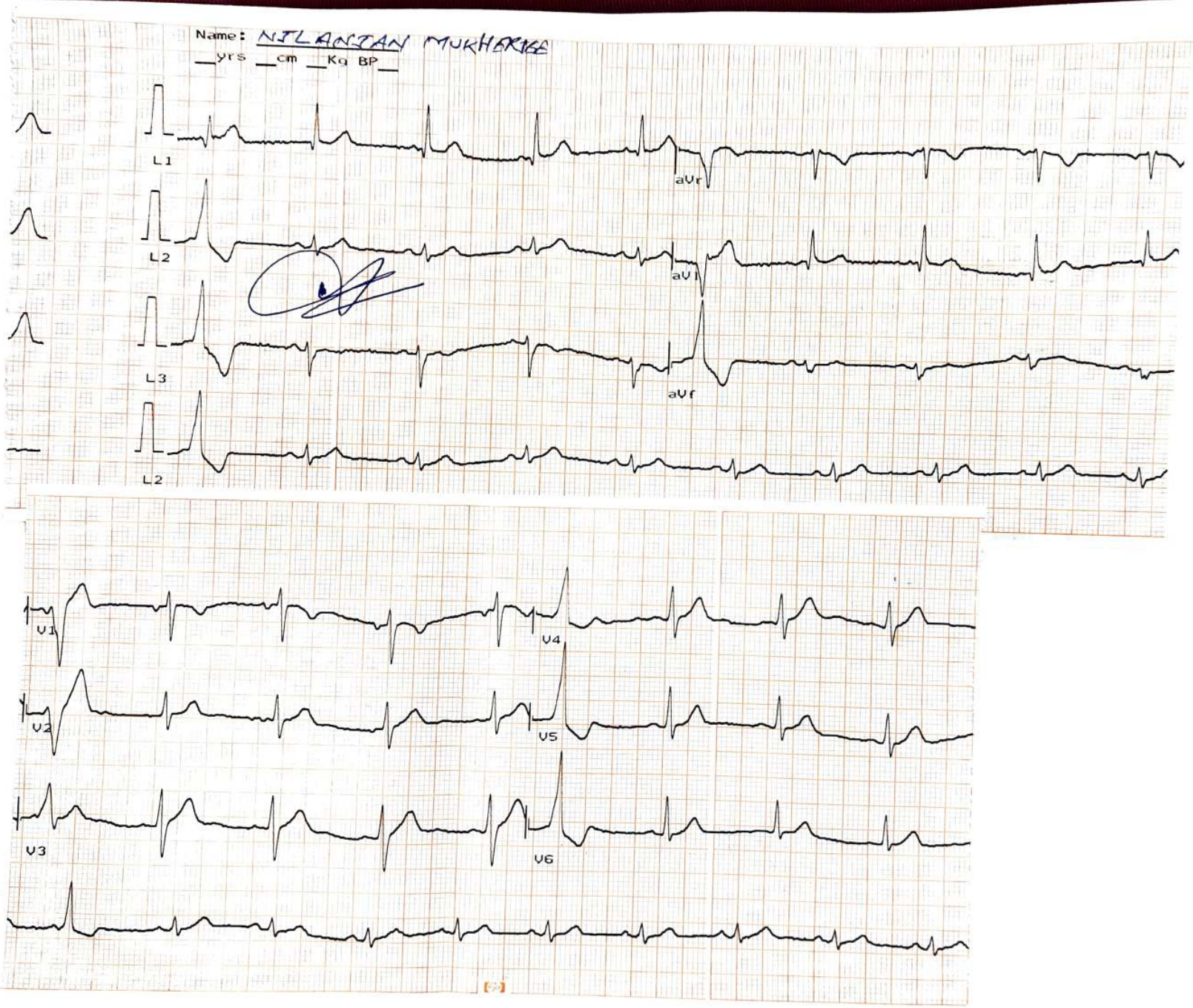
Signature of the Cardiologist
Name & Address
Qualification
Code No.

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

ELITE HEALTH CENTER DELHI

Name: NILANJAN MUKHERJEE

__yrs __cm __Kg BP__



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

ELITE HEALTH CENTER
DELHI

ELITE DIAGNOSTIC

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

HAEMOGRAM

Test	Result	Units	Normal Range
Hemoglobin	14.12	gm/dl	12-18

BIOCHEMISTRY-(SBT-13)

Blood Sugar Fasting	92.47	mg/dl	70-115
S. Cholesterol	168.17	mg/dl	130-250
H.D.L. Cholesterol	70.48	mg/dl	35-90
L.D.L. Cholesterol	115.40	mg/dl	0-160
S.Triglycerides	98.39	mg/dl	35-160
S.Creatinine	0.90	mg/dl	0.5-1.5
Blood Urea Nitrogen (BUN)	12.32	mg/dl	06-21
Albumin	4.1	gm%	3.2-5.50
Globulin	2.9	gm%	2.00-4.00
S.Protein Total	7.0	gm%	6.00-8.5
AG/Ratio	1.50		0.5-3.2
Direct Bilirubin	0.2	mg/dl	0.00-0.3
Indirect Bilirubin	0.6	mg/dl	0.1-1.00
Total Bilirubin	0.8	mg/dl	0.1-1.3
S.G.O.T.	29.17	IU/L	00-42
S.G.P.T.	30.82	IU/L	00-42
Gamma Glutamyl Transferase (GGT)	40.40	IU/L	00-60
S. Alk. Phosphatase	46.85	IU/L	28-111 (Children 151-471)

SEROLOGY

Test Name :*Human Immunodeficiency Virus I&II {HIV}(Elisa method)*

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

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

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
Consultant Pathologist

7091, Gali no. 10, Mata Rameshwari Marg, Nehru Nagar Karol Bagh, Delhi-110005 Contact : +91-9650080041, 9871144570

NOTE : Not to the final Diagnosis if highly abnormal or do not correlate clinically. Please refer to the lab without any hasitation. This report is not for medico – legal cases.

ELITE DIAGNOSTIC

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. MATHUR
M.B.B.S. MD (PATH)
REGD.NO. 19702
Consultant Pathologist

NOTE : Not to the final Diagnosis if highly abnormal or do not correlate clinically. Please refer to the lab without any hasitation. This report is not for medico – legal cases.

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	N.A

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

Declaration

You Mr/Ms Nilanjan Mukherjee 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 ____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: DELHI
Date: 28/10/2024

Signature of Medical Examiner
Name & Code No:
Stamp:

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

ELITE HEALTH CENTER
DELHI

भारत सरकार

Government of India

आधार

नीलांजन मुखार्जी

Nilanjan Mukherjee

जन्म तिथि / DOB : 01/12/1983

पुरुष / Male

9341 2068 1171

Issue Date: 06/04/2013

आधार पहचान का प्रमाण है, नागरिकता का नहीं।

Aadhaar is a proof of identity, not of citizenship.

9341 2068 1171

मेरा आधार, मेरी पहचान


ELITE
DIAGNOSTIC
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
Google