LIFE INSURANCE CORPORATION OF INDIA

JUVENILE FMR

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

Proposal No. 5979

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

Name of the child: (~~Master~~/ Miss) AMAY JAIN				
Mark of identification: Mole/Scar/any other (specify location) NO				
Current ID provided	Student	Passport	Latest School Report Card	Others(specify)
Age of the child: 1 Years/Months 1			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: 82 cms Weight of the child: 11 kgs

Pulse and character 96/M Blood Pressure 90/110 mm of Hg

Presence of any congenital defects or abnormalities: Yes / ~~No~~

(If yes, please provide details)

For Children Below 2 yrs:

Head Circumference 48 cms Chest Circumference 54 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 Sibling 2 No

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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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: Shweta Jain Name of the parent SHWETA JAIN

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 05 day of 10 2024 at 9:15 a.m./p.m.

HEALTH CENTRE DELHI

Shweta Jain (MOTHER)

Signature / thumb impression of the examinee

Signature of the Medical Examiner
Name & Address Dr. BINDU
Qualification MBBS, MD
Code:
Limit Reg. No. 33485

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

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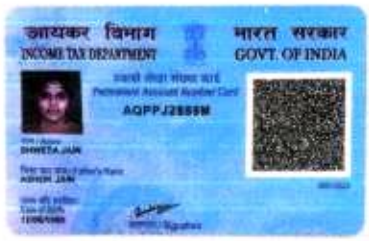

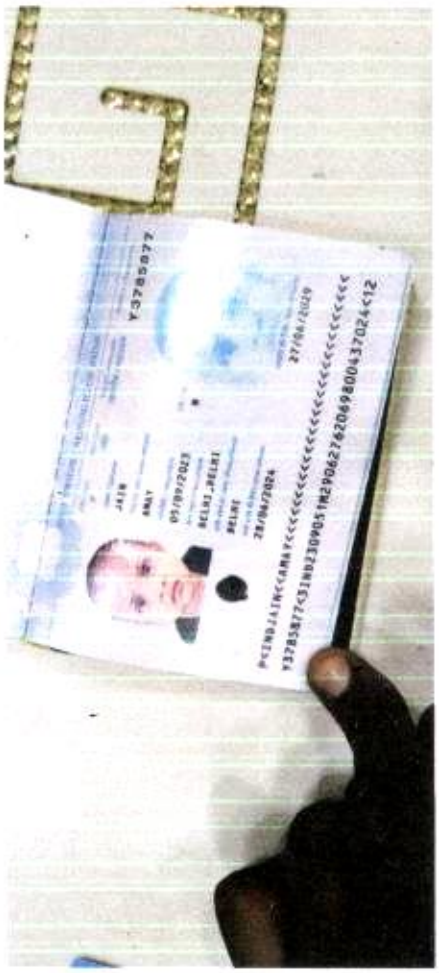

Dr. BINDU
MBBS, MD
Reg. No. 53435

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