

Date: 06-10-2024

To,  
LIC of India  
Branch Office

Proposal No. 2826

Name of the Life to be assured BHAVYA ARORA

The Life to be assured was identified on the basis of \_\_\_\_\_

I have satisfied myself with regard to the identity of the Life to be assured before conducting tests / examination for which reports are enclosed. The Life to be assured has signed as below in my presence.

Dr. RAINA KHAN  
MBBS, DMRD  
Reg. No. 25508

Signature of the Pathologist/ Doctor

Name:

I confirm, I was on fasting for last 10 (ten) hours. All the Examination / tests as mentioned below were done with my consent.

[Signature]  
(Signature of the Life to be assured)

Name of life to be assured:

Reports Enclosed:


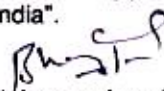

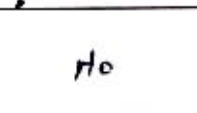
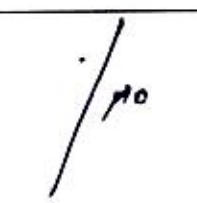
Sr. No.	Reports Name	Sr. No.	Reports Name
1	FMR ✓	9	Lipidogram ✓
2	Rest ECG with Tracing	10	BST (Blood Sugar Test-Fasting & PP) Both
3	Haemogram	11	Hba1c
4	Hb% ✓	12	FBS (Fasting Blood Sugar)
5	SBT-13 ✓	13	PGBS (Post Glucose Blood Sugar)
6	Elisa for HIV	14	CTMT with Tracing
7	RUA ✓	15	Proposal and other documents
8	Chest X-Ray with Plate (PA View)		

16. Questionnaires: \_\_\_\_\_

17. Others (Please Specify) \_\_\_\_\_

Remarks of Med Save TPA Services PVT LTD  
Authorized Signature,



 <b>LIC</b> LIC MEDICAL EXAMINER'S REPORT Form No LIC03-001 (Revised 2020)	Branch Code:	
	Proposal/ Policy No: <u>2226</u>	
	MSP name/code :	
	Date & Time of Examination:	
	Medical Diary No & Page No:	
Mobile No of the Proposer/Life to be assured: _____ Identity Proof verified: <u>UD</u> ID Proof No. <u>2998</u> ( 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: <u>BHAVYA ARORA</u>	
2	Date of Birth: <u>15/05/1998</u> Age: <u>26 Yr</u> Gender: <u>M</u>	
3	Height (In cms): <u>180</u> Weight ( in kgs ) : <u>72</u>	
4	Required only in case of Physical MER	
	Pulse : <u>68/m</u> Blood Pressure (2 readings): 1. Systolic <u>118</u> Diastolic <u>78</u> 2. Systolic <u>118</u> Diastolic <u>78</u>	
<b>ASCERTAIN THE FOLLOWING FROM THE PERSON BEING EXAMINED</b>  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 <b>treatment/ medication</b> including alternate medicine like ayurveda, homeopathy etc ? b. Undergone any <b>surgery / hospitalized</b> 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 <b>diagnostic tests</b> ? Please specify date , reason ,advised by whom & findings.	
7	Suffering or ever suffered from <b>Novel Coronavirus (Covid-19)</b> 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	





8	<p>a. Suffering from <b>Hypertension</b> (high blood pressure) or <b>diabetes</b> 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 <b>endocrine disorders</b> 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>	No
9	<p>a. Any history of chest pain, <b>heartattack</b>, palpitations and breathlessness on exertion or irregular heartbeat?</p> <p>b. Whether suffering from <b>high cholesterol</b>?</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>	No
10	Suffering or ever suffered from any disease related to <b>kidney</b> such as kidney failure, kidney or ureteral stones, blood or pus in urine or prostate?	No
11	Suffering or ever suffered from any <b>Liver disorders</b> like cirrhosis, hepatitis, jaundice, or disorder of the Spleen or from any <b>lung related</b> or respiratory disorders such as Asthma, bronchitis, wheezing, tuberculosis breathing difficulties etc.?	No
12	Suffering or ever suffered from any <b>Blood disorder</b> like anaemia, thalassemia or any Circulatory disorder?	No
13	Suffering or ever suffered from any form of <b>cancer</b> , leukaemia, tumor, cyst or growth of any kind or enlarged lymph nodes?	No
14	Suffering or ever suffered from Epilepsy, <b>nervous disorder</b> , multiple sclerosis, tremors, numbness, paralysis, brain stroke?	No
15	Suffering or ever suffered from any <b>physical Impairment</b> 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 <b>disorder of the Stomach</b> / 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 / <b>psychiatric disorder</b>?</p> <p>b. Whether on treatment or ever taken any treatment, if yes, please give details of treatment, prescribed medicine and dosages</p>	No
18	Is there any <b>abnormality</b> 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 <b>HIV /AIDS/ Sexually transmitted diseases</b> (e.g. syphilis, gonorrhea, etc.)	No
20	Ascertain if any other condition / disease / adverse habit (such as <b>smoking/ tobacco chewing/ consumption of alcohol/drugs</b> 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

NA

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 \_\_\_\_\_ 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.

*[Handwritten Signature]*

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 06 day of 10 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.

Place: DELHI  
Date: 06/10/2024



Signature of Medical Examiner  
Name & Code No:  
Stamp:

Dr. RAINAKHIAN  
MBBS, DMRD  
Reg. No. 25508







Dr. RAJNANKHAN  
MBBS, MD  
Reg. No. 25508



# irine diagnostic

healthpartner

S. No. : 06/OCT/07  
Name : MR BHAVYA ARORA  
Ref. by : LIFE INSURANCE CORPORATION  
Date : 06-10-2024  
AGE : 26Years  
SEX : MALE

## H A E M A T O L O G Y

Test	Result	Units	Normal Range
Hemoglobin	14.5	gm%	12-16

DR. SHILPI GUPTA  
M.B.B.S.MD(Path) 64715  
Consultant Pathologist

8595347044

irinediagnostic@gmail.com

DD-23 KALKAJI DELHI :- 110019



# urine diagnostic

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## URINE EXAMINATION

### PHYSICAL EXAMINATION

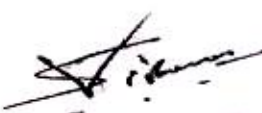
COLOUR	YELLOW
REACTION	ACIDIC
APPEARANCE	CLEAR
ALBUMIN	NIL
SUGAR	NIL
SPECIFIC GRAVITY	1.010

### CHEMICAL EXAMINATION

ALBUMIN	NIL
SUGAR	NIL
ACETONE	NIL
BLOOD	NIL
BILE SALT	NIL
BILE PIGMENT	NIL
UROBILINOGEN	NIL

### MICROSCOPIC EXAMINATION

PUS CELLS	1-2/HPF
EPITHELIAL CELLS	1-2/HPF
RBC	NIL /HPF
BACTERIA	NIL
CASTS	NIL
CRYSTALS	NIL
OTHERS	NIL

  
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SEX : MALE

## S E R O L O G Y

\*\*Test Name : HIV I & II (ELISA METHOD) : Human Immunodeficiency  
Result : "Non-Reactive"  
Normal-Range : "Non-Reactive"

  
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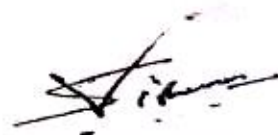
## B I O C H E M I S T R Y

Test	Result	Units	Normal Range
FASTING BLOOD SUGAR	79	mg/dl.	(60-110)
TOTAL BILIRUBIN	0.75	mg/dl.	(0.1-1.2)
CONJUGATED (D.Bilirubin)	0.44	mg/dl.	(0.00-0.6)
UNCONJUGATED (I.D.Bilirubin)	0.21	mg/dl.	(0.1-1.0)
TOTAL PROTEIN	6.9	mg/dl.	(6.0-8.3)
ALBUMIN	4.3	mg/dl.	(3.5-5.0)
GLOBULIN	2.6	mg/dl.	(2.3-3.5)
A/G RATIO	1.65		(1.0-3.0)
S.G.O.T. (AST)	25	IU/L	(5.0-34.0)
S.G.P.T. (ALT)	28	IU/L	(5.0-40.0)
GAMMA GT	32	U/L	(9-45)
ALKALINE PHOSPHATASE	120	U/L	(80-200)
URIC ACID	5.5	mg/dl.	(4.4-7.2)
SERUM CHOLESTEROL	178	mg/dl.	(150-200)
HDL CHOLESTEROL	42	mg/dl.	(30-63)
S. TRIGLYCERIDES	115	mg/dl.	(60-160)
LDL	99	mg/dl.	(UPTO-150)
VLDL	35	mg/dl.	(23-45)
SERUM CREATININE	0.78	mg%	(0.6-1.2)
BUN	13	mg/dl	(02-18)

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