


Irene Hospital
DD-23, Kalkaji Extension, New Delhi-110019
Tel.: 011-49012225

यहाँ पर प्रसव पूर्व लिंग (पैरेंट्स को बच्चे का लिंग या लड़की) की पहचान नहीं की जाती। यह दण्डनीय अपराध है।
बच्चे के लिंग के लिए सूचना या मांग करना पीसी और पीएनडीटी अधिनियम के तहत एक दण्डनीय अपराध है।

Here Pre-Natal Sex determination and disclosure of sex (Boy or Girl before entry of twins) is not done. It is prohibited under law.
SEEKING / ASKING FOR CHILD IS ALSO A PUNISHABLE OFFENCE UNDER PC & PNDT ACT.
In Case Of Any Complaint Contact: Dr. South East Wing, 2nd Floor, 2nd Stage Building
LAJPT NAGAR, NEW DELHI, INDIA



 **GPS Map Camera**

Check In

New Delhi, Delhi, India

Dd-23, Block Dd, Kalkaji, New Delhi, Delhi 110019, India

Lat 28.544664° Long 77.258154°

13/11/24 11:10 AM GMT +05:30





भारत सरकार
Government of India

सुरेश भल्ला

Suresh Bhalla

जन्म तिथि/ DOB: 17/07/1966

महिला / FEMALE

9195



मेरा आधार, मेरी पहचान



Date 13/11/2024

To,
LIC of India
Branch Office

Proposal No. 167220854

Name of the Life to be assured SURESH BHALLA

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.

Signature of the Pathologist/ Doctor

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

Name:

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

S. Bhalla

(Signature of the Life to be assured)

Name of life to be assured:

Reports Enclosed:

Reports Name	Yes/No	Reports Name	Yes/No
ELECTROCARDIOGRAM		PHYSICIAN'S REPORT	
COMPUTERISED TREADMILL TEST		CERTIFICATION & DECLARATION FORMAT	
HAEMOGRAM		MEDICAL EXAMINER'S REPORT	YES
LIPIDOGRAM		BST (Blood Sugar Test-Fasting & PPI) Both	
BLOOD SUGAR TOLERANCE REPORT		FBS (Fasting Blood Sugar)	
SPECIAL BIO-CHEMICAL TESTS - 13 (SBT-13)		PGBS (Post Glucose Blood Sugar)	
ROUTINE URINE ANALYSIS		Proposal and other documents	
REPORT ON X-RAY OF CHEST (P.A. VIEW)		HBM	
ELISA FOR HIV		Other Test	

Comment Medsave Health Insurance TPA Ltd.

Authorized Signature,



Dr. RAJINDER KIAN
Reg. No. Z05008



भारत सरकार
Government of India

 सुरेश भट्टा
Suresh Bhatta
जन्म तिथि/ DOB: 17/07/1986
महिला / FEMALE

9195



मेरा आधार, मेरी पहचान

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

Branch Code:

Proposal/ Policy No: 167320854

MSP name/code :

Date & Time of Examination:

Medical Diary No & Page No:

Mobile No of the Proposer/Life to be assured:

Identity Proof verified: UIDID Proof No. 9195

(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".

S. BhallaSignature/ Thumb impression of Life to be assured
(In case of Physical Examination)

1	Full name of the life to be assured: <u>SURESH BHALLA</u>	
2	Date of Birth: <u>17-07-1966</u>	Age: <u>58-10</u> Gender: <u>F</u>
3	Height (In cms): <u>164</u>	Weight (in kgs): <u>79.1</u>

4	Required only in case of Physical MER	
	Pulse: <u>78/4</u>	Blood Pressure (2 readings): 1. Systolic <u>122</u> Diastolic <u>82</u> 2. Systolic <u>122</u> Diastolic <u>82</u>

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
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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
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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), Rhinorrhoea (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	<p>a. Suffering from Hypertension (high blood pressure) or diabetes 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 endocrine disorders 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, heartattack, palpitations and breathlessness on exertion or irregular heartbeat?</p> <p>b. Whether suffering from high cholesterol?</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 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	<p>a. Suffering from Depression/Stress/ Anxiety/ Psychosis or any other Mental / psychiatric disorder?</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 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, gonorrhoea, 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



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

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No

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.

S. Dhalla

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 13 day of 11 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: 13/11/2024



Signature of Medical Examiner
Name & Code No:
Stamp:



Dr. RAINA KHAN
M.B.B.S., D.M.D.
Reg. No. 25508