

Date: 09/10/2024

To,
LIC of India
Branch Office

Proposal No. 2771

Name of the Life to be assured FAIZ KHAN

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.

Rahis Khan

(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		IDENTIFICATION & DECLARATION FORMAT	
HAEMOGRAM		MEDICAL EXAMINER'S REPORT	
LIPIDOGRAM		BST (Blood Sugar Test-Fasting & PP) 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)		Hb%	
ELISA FOR HIV		Other Test	JMER

Comment Medsave Health Insurance TPA Ltd.

Authorized Signature,



LIFE INSURANCE CORPORATION OF INDIA

JUVENILE FMR

Zone : NORTHERN

Division : Delhi D.O.-II

Branch

Proposal No. 2771

Agent/D.O. Code:

Introduced by: (name & signature)

Name of the child: (Master/ Miss) <u>FAIZ KHAN</u>				
Mark of identification: Mole/Scar/any other (specify location) <u>No</u>				
Current ID provided	Student <input checked="" type="checkbox"/>	Passport	Latest School Report Card	Others(specify) <u>SCHOOL ID</u>
Age of the child: <u>10</u> Years/Months		SEX: M <input checked="" type="checkbox"/> / F <input type="checkbox"/>		
Birth History: FTND / Forceps / Caesarean/ Other (Please tick the relevant) <u>None</u>				
A. Details of Physical Examination				
For all children:				
Height of the child: <u>137</u> cms		Weight of the child: <u>37</u> kgs		
Pulse and character <u>96/4</u>		Blood Pressure <u>100/60</u> mm of Hg		
Presence of any congenital defects or abnormalities: Yes / <u>No</u> (If yes, please provide details)				
For Children Below 2 yrs:				
Head Circumference <u>52</u> cms		Chest Circumference <u>72</u> cms		
B. Medical History:				
1) Is the proposed insured presently in good health?		Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>		
2) Does the proposed insured have any physical and mental handicap or deformity?		Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> 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 <input type="checkbox"/> / No <input checked="" type="checkbox"/> 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 <input type="checkbox"/> / No <input checked="" type="checkbox"/> If yes provide details:		
5) Is the child's behavior / appearance / mental ability in line with his current age?		Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/> If no provide details:		
6) If school going, has proposed insured taken any sick leave from school in the last 2 years?		Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> 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, thalassaemia, cancer, kidney disease, any other hereditary / familial disorders		Father: Mother : Sibling 1 Sibling 2 <u>No</u>		
C. Immunization History: (Mandatory for ages < and equal to 5 yrs)				
Vaccinated for				
1. OPV:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	2. DPT:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	
3. BCG:	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	4. Hepatitis B:	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	
5. Mumps, Measles, Rubella:	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	6. Typhoid (above 1 Yr):	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	



7. Hepatitis A (Above 1 Yr): Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>		
D. Medical Examination		
Do you find any evidence of abnormality, disease or surgery of:		If yes please elaborate
1) the respiratory system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
2) the central and peripheral nervous system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3) the genito urinary system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
4) the abdominal organs?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
5) the head, face, mouth, throat, eyes, ears ,nose and neck?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
6) the skin, muscles, bones and joints?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7) The Cardiovascular system:		
a) Are the peripheral pulses abnormal?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
b) Is there any evidence of heart enlargement?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
c) Are there murmurs or abnormal heart sounds?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
d) Do you suspect any abnormality of the cardiovascular system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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: Rahis Kha Name of the parent RAISUDDIN KHAN

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 09 day of 10, 2024 at 9:30 a.m./p.m.

FaiZ KHAN
Signature / thumb impression
of the examinee

Dr. RAINA KHAN
Signature of the Medical Examiner
MBBS DMRD
Name & Address
Reg. No. 25508
Qualification
Code:
Limit



Confidential Comments from Doctor

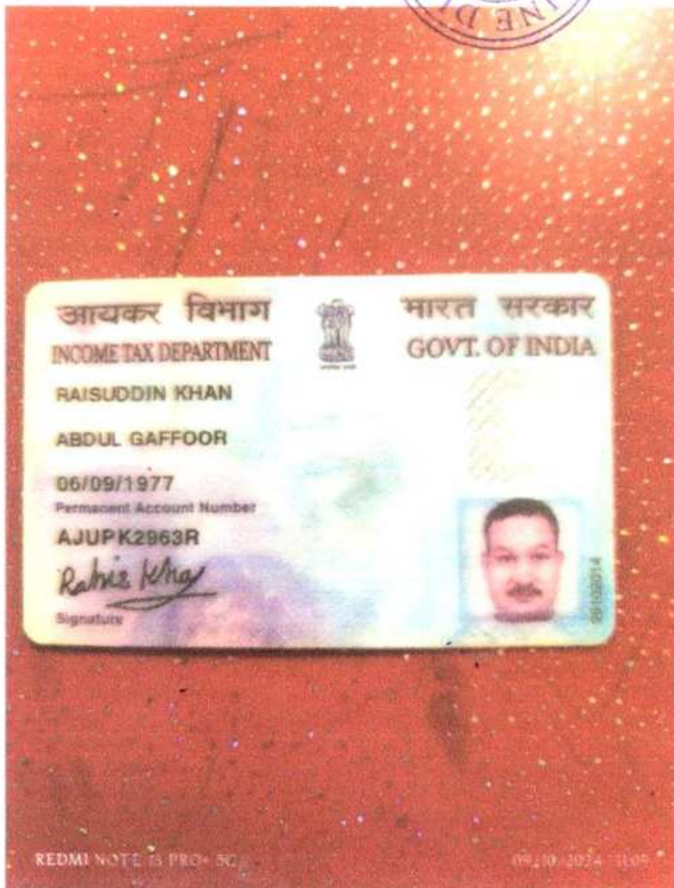
- Are there any points on which you suggest further information be obtained? YES NO
- For physical investigations no
 - For mental level assessment no



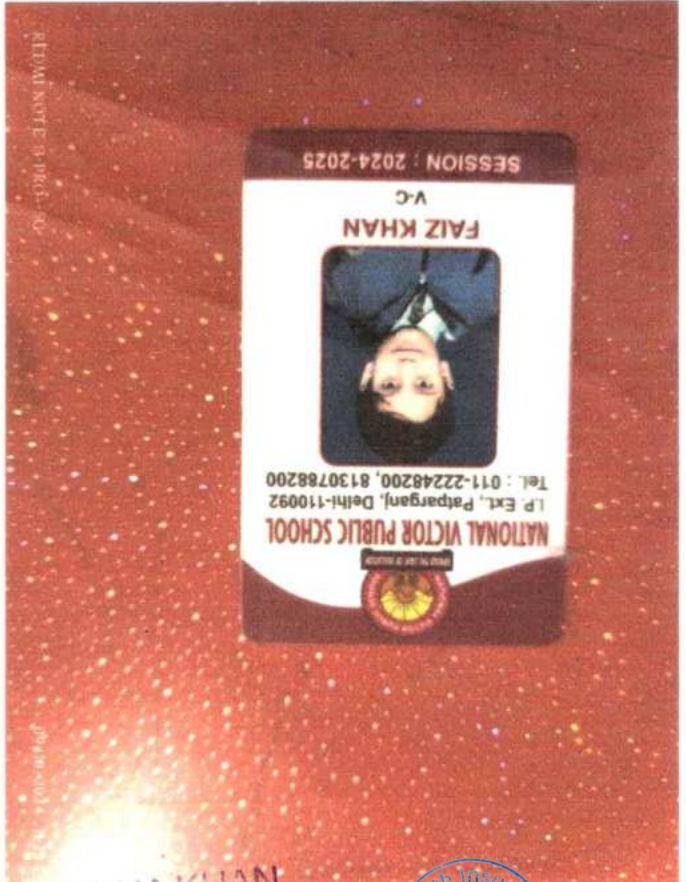
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 Long 77.25818°
 08/10/24 09:46 AM GMT +05:30



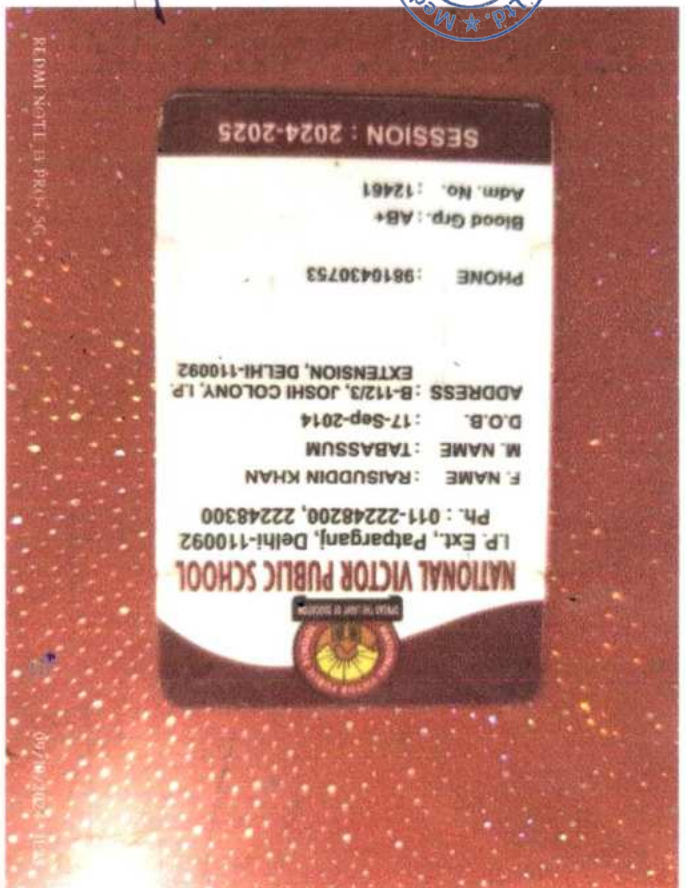
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