

Irene Hospital
DD-23, Kalkaji Extension, New Delhi-110019
Tel.: 011-4992 2225

यहाँ पर प्रसव पूर्व लिंग (पैन्, लैंग, बच्चे, लड़का या लड़की) की पहचान नहीं की जाती। यह दण्डनीय अपराध है।
बच्चे के लिंग के लिए पूछना या मांग करना पीसी और पॉएनडीटी अधिनियम के तहत एक दण्डनीय अपराध है।

Here Pre-Natal Sex determination and disclosure of sex (Boy or Girl before birth) of foetus is prohibited and punishable under law.

SEEKING / DISCLOSURE OF THE SEX OF CHILD IS ALSO A PUNISHABLE OFFENCE UNDER PC & PNDT ACT


In Case Of Any Offence Under PC & PNDT ACT.
Contact : 011-4992 2225, Old Gargi College Building, NEW DELHI- 110024, 011-26479482.

Ultrasound
अल्ट्रासाउण्ड

ECG
हृदयग्राही
हृदयग्राही

ECG
हृदयग्राही
हृदयग्राही



 **GPS Map Camera**

Check In

New Delhi, Delhi, India
Dd-23, Block Dd, Kalkaji, New Delhi, Delhi 110019, India
Lat 28.544666° Long 77.258156°
13/11/24 11:10 AM GMT +05:30



Google

Transport Department Government of NCT of Delhi
Authorisation to Drive Vehicle Class throughout India

DL No : DL03 19990230364

(R)

Name : BALRAJ BHALLA

S/D/W : C S BHALLA

DOB : 26/06/1964

Blood Group : U

Class of Vehicle

Date Of Issue

LMV

16/08/1999

MCWG

16/08/1999



Address : 118-A/1 ZAMRUD PUR G K I GREATER
KAILASH, SOUTH DELHI 110048

(Sign of DL Holder)

Issue Date : 05/12/2019
Validity(NT) : 04/12/2024
Validity(TR) : NA
Adpt.Veh.No : NA

Licensing Authority
SZ, SHEIKH SARAI



Date 13/11/2024

To,
LIC of India
Branch Office

Proposal No. 167320853

Name of the Life to be assured BAL RAY 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.

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.

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		IDENTIFICATION & DECLARATION FORMAT	
HAEMOGRAM		MEDICAL EXAMINER'S REPORT	Yes
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)		libm	
ELISA FOR HIV		Other Test	

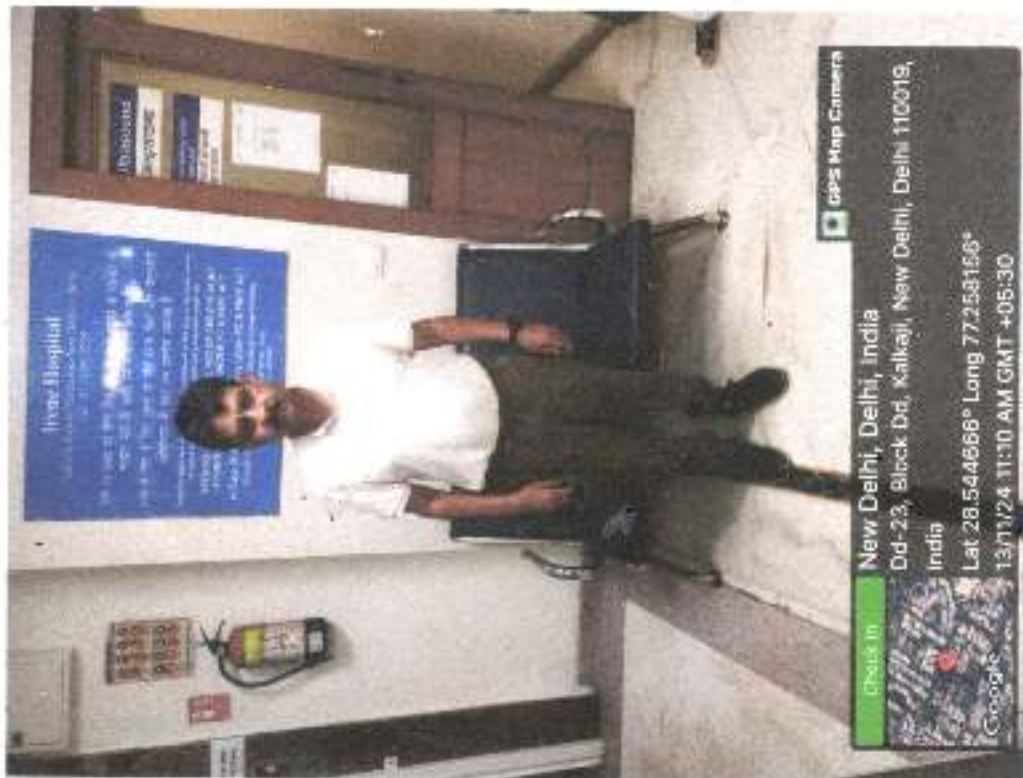
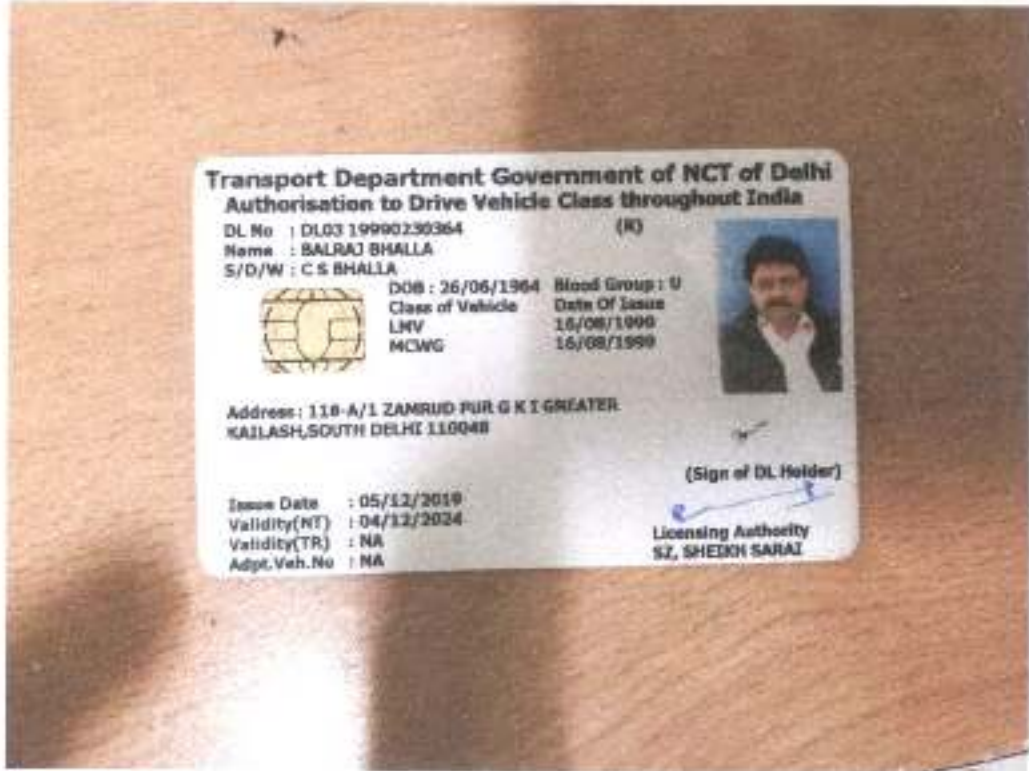
Comment Medsave Health Insurance TPA Ltd.

Authorized Signature,





DR RAMAN ANAND
DMRD
Reg. No. 25503



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

Branch Code:

Proposal/ Policy No: 167320853

MSP name/code:

Date & Time of Examination:

Medical Diary No & Page No:

Mobile No of the Proposer/Life to be assured:

Identity Proof verified: DL ID Proof No. DL0319990270364
(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: BALRAJ BHALLA		
2	Date of Birth: 28/06/1964	Age: 60 y	Gender: M
3	Height (In cms): 159	Weight (in kgs): 62.4	
4	Required only in case of Physical MER		

Pulse: 80/4	Blood Pressure (2 readings):
	1. Systolic 118 Diastolic 78
	2. Systolic 118 Diastolic 78

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	<p>a. Whether receiving or ever received any treatment/ medication including alternate medicine like ayurveda, homeopathy etc ?</p> <p>b. Undergone any surgery / hospitalized for any medical condition / disability / Injury due to accident?</p> <p>c. Whether visited the doctor any time in the last 5 years ?</p> <p>If answer to any of the questions 5(a) to (c) is yes -</p> <p>i. Date of surgery/accident/injury/hospitalisation</p> <p>ii. Nature and cause</p> <p>iii. Name of Medicine</p> <p>iv. Degree of impairment if any</p> <p>v. Whether unconscious due to accident, if yes, give duration</p>	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



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 or 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

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.

Rahana

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. RAJNA KHAN
MBBS, DMRD
Reg. No. 25508