

LIFE INSURANCE CORPORATION OF INDIA

JUVENILE FMR

Zone _____ Division _____ Branch _____

Proposal No. _____

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

Name of the child: (Master/ Miss)			
Mark of identification: Mole/Scar/any other (specify location)			
Current ID provided	Student	Passport	Latest School Report Card Others(specify)
Age of the child: _____ Years/Months		SEX: M <input type="checkbox"/> / F <input type="checkbox"/>	
Birth History: FTND / Forceps / Caesarean/ Other (Please tick the relevant)			
A. Details of Physical Examination			
For all children:			
Height of the child: _____ cms		Weight of the child: _____ kgs	
Pulse and character _____		Blood Pressure _____ mm of Hg	
Presence of any congenital defects or abnormalities: Yes / No (If yes, please provide details)			
For Children Below 2 yrs:			
Head Circumference _____ cms		Chest Circumference _____ cms	
B. Medical History:			
1) Is the proposed insured presently in good health?		Yes <input 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 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 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 type="checkbox"/> If yes provide details:	
5) Is the child's behavior / appearance / mental ability in line with his current age?		Yes <input type="checkbox"/> / No <input type="checkbox"/> If yes 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 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	
C. Immunization History: (Mandatory for ages < and equal to 5 yrs)			
Vaccinated for			
1. OPV: Yes <input type="checkbox"/> / No <input type="checkbox"/>		2. DPT: Yes <input type="checkbox"/> / No <input type="checkbox"/>	
3. BCG: Yes <input type="checkbox"/> / No <input type="checkbox"/>		4. Hepatitis B: Yes <input type="checkbox"/> / No <input type="checkbox"/>	
5. Mumps, Measles, Rubella: Yes <input type="checkbox"/> / No <input type="checkbox"/>		6. Typhoid (above 1 Yr): Yes <input type="checkbox"/> / No <input type="checkbox"/>	
7. Hepatitis A (Above 1 Yr) : Yes <input type="checkbox"/> / No <input 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 type="checkbox"/> No	
2) the central and peripheral nervous system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3) the genito urinary system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4) the abdominal organs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5) the head, face, mouth, throat, eyes, ears ,nose and neck?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6) the skin, muscles, bones and joints?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7) The Cardiovascular system:			
a) Are the peripheral pulses normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Is there any evidence of heart enlargement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c) Are there murmurs or abnormal heart sounds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
d) Do you suspect any abnormality of the cardiovascular system?	<input type="checkbox"/> Yes	<input 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: _____ Name of the parent _____

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 _____ on the _____ day of _____ 200 at _____ a.m./p.m.

Signature / thumb impression
of the examinee

Signature of the Medical Examiner
Name & Address
Qualification
Code:
Limit

Confidential Comments from Doctor

Are there any points on which you suggest further information be obtained? YES NO

- For physical investigations
- For mental level assessment