

# 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
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)			
<b>A. Details of Physical Examination</b>			
<b>For all children:</b>			
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)			
<b>For Children Below 2 yrs:</b>			
Head Circumference _____ cms		Chest Circumference _____ cms	
<b>B. Medical History:</b>			
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	
<b>C. Immunization History: (Mandatory for ages &lt; and equal to 5 yrs)</b>			
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"/>		
<b>D. Medical Examination</b>			
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

\_\_\_\_\_