

Revised format for FMR of HEALTH PLUS PLAN

Life Insurance Corporation of India (Established by the Life Insurance Corporation Act, 1956) MEDICAL EXAMINER'S CONFIDENTIAL REPORT		F.No. LIC03 -001	
		Branch No.	
		Proposal/Policy No.	
		Medical Diary No./Page No.	
1.	Full Name of the Life to be examined		Case No. Month Year
2.	Age:	Sex:	Identification marks:
3.	Introducer's name & designation		Introducer's signature:
4.	Height (cms) :		Weight (kgs):
	Chest (cms) (over nipple):		Girth of abdomen (cms) (over navel)
	Pulse Rate p.m.		Full Expiration (cms):
	Blood Pressure		Full inspiration (cms):
		1st reading	Systolic
		2nd reading	Diastolic
If answer/s to any of the following questions is 'Yes', please give full details and ask L.A. to submit relevant documents with proposal form.			
5.	Ascertain from the L.A. whether at any time in the past he/she –		
	(a)	was hospitalised.	
	(b)	was operated.	
	(c)	met with accident	
	(d)	has undergone any bio-chemical, radiological, Cardiological or other test.	
	(e)	is currently under any treatment.	
6.	Is there any abnormality observed on examination of Eyes (partial/total blindness), Ears (deafness), Nose, Throat or Mouth or any physical impairment.		
7.	Is there any externally visible swelling of lymph glands, joints or other organs		
8.	Are there any symptoms and/or signs suggestive of abnormality of -		
	(a)	Cardiovascular system	
	(b)	Respiratory system	
	(c)	Central or peripheral nervous system	
	(d)	Digestive System	
	(e)	Musculoskeletal system including spinal disorders	
	(f)	Genitourinary system	

9.	Is there evidence of enlargement of liver or spleen?	
10.	Is hernia present	
11.	Is there any evidence of operation, if so state –	
	(a) Date of operation	
	(b) Nature & cause	
	(c) Location, size & condition of scar	
	(d) degree of impairment	
12.	Is there any evidence of injury due to accident or otherwise –	
	(a) Date of injury	
	(b) Nature of injury	
	(c) Degree of impairment	
	(d) Duration of unconsciousness, if any.	
13.	Are there any other adverse features in habit or health, past or present, which you consider relevant, if so give details	
14.	For female only –	
	(a) Is there any disease of breasts	
	(b) Do you suspect any disease of uterus, cervix or ovaries	
	(c) Is there any evidence of pregnancy, if so give duration.	
15.	On examination whether he/she appears mentally and physically healthy?	

I hereby certify that I have, this day, examined the above life to be assured personally, in private, and recorded in my own hand (i) the true and correct findings (ii) the answers to Question No.5 as ascertained from the person examined.

I declare that the person examined signed (affixed his/her thumb impression) in the space earmarked below, in my presence and that I am not related to him/her or the Agent or the Development Officer.

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

Signature of the L.A.

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