

FINDINGS OF TEST REPORTS :

1. Glycoylated Haemoglobin : _____
2. Urine albumin urea: _____
3. Eye Check-up : _____
4. Whole abdomen and pelvic Sonography : _____
5. ECG : _____
6. TMT : _____
7. X-RAY KNEE : _____

GIVE DETAILS OF FAMILY HISTORY:

- Family History of hypertension (BP) _____
- Family History of Heart Disease _____
- Family History of Diabetes Mellitus (DM) _____
- Diabetes Type-1 or Type-2 _____
- Family History of Cancer _____
- Family History of Thalasemia/any blood disorder _____
- Family History of asthma _____
- For females, Family History of Breast Cancer _____
- Any other details of family history: _____

HABITS:

Alcohol: Yes/ No, regular / occasional / social, since when _____ yrs, Quantity _____ /day.
 Smoking: Yes/ No, regular/occasional / social, since when _____ yrs, Quantity _____ /day.
 If stopped since when: _____
 Any Other _____

RECOMMENDATION / OBSERVATION OF THE DOCTOR:

a) Have you observed any variation from the SELF-DECLARATION FORM AND TEST REPORT IF yes, give details: _____

b) Any Specific Finding upon medical examination indicating whether any disease/ailment is to be excluded from the scope of the policy.: (Please Specify) _____

I confirm that I have examined the client after verification of his /her identify and the findings stated above are true and correct to the best of my knowledge.

Date: _____

Place: _____

Name of the Medical Examiner _____

Signature of Medical Examiner _____

FOR OFFICE USE ONLY

Underwriter Comments/Recommendations: _____

Dispatched to _____

on _____

Approved by _____

Signature & Date _____