LIFE INSURANCE CORPORATION OF INDIA

JUVENILE FMR

Zone:_____ Division : _____ Branch: _____
Proposal No. _____
Full Name of Life to be Assured: _____ Age / Sex _____
Introduced by _____ Agent / Dev.Officer Code _____

Name of the child: (Master/ Miss)				
Marks of identification: Mole/Scar/any others (specify location)				
Current Identity provided	School/college Identity card	Passport	Latest School Report Card	Others(specify)
Age of the child: _____Years/Months			SEX: M ☐ / F ☐	
Birth History: FTND / Forceps / Caesarean/ Others (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 ☐ / No ☐
2) Does the proposed insured have any physical and mental handicap or deformity?	Yes ☐ / No ☐ 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 ☐ / No ☐ 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 ☐ / No ☐ If yes provide details:
5) Is the child's behaviour / appearance / mental ability in line with his current age?	Yes ☐ / No ☐ If No provide details:
6) If school going, has proposed insured taken any sick leave from school in the last 2 years?	Yes ☐ / No ☐ 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, thallassaemia, 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 ☐ / No ☐	2. DPT:	Yes ☐ / No ☐
3. BCG:	Yes ☐ / No ☐	4. Hepatitis B:	Yes ☐ / No ☐
5. Mumps, Measles, Rubella:	Yes ☐ / No ☐	6. Typhoid (above 1 Yr):	Yes ☐ / No ☐
7. Hepatitis A (Above 1 Yr) :	Yes ☐ / No ☐		

D. Medical Examination			
Do you find any evidence of abnormality, disease or surgery of:			If yes please elaborate
1) the respiratory system?	☐ Yes	☐ No	
2) the central and peripheral nervous system?	☐ Yes	☐ No	
3) the genito urinary system?	☐ Yes	☐ No	
4) the abdominal organs?	☐ Yes	☐ No	
5) the head, face, mouth, throat, eyes, ears, nose and neck?	☐ Yes	☐ No	
6) the skin, muscles, bones and joints?	☐ Yes	☐ No	
7) The Cardiovascular system:			
a) Are the peripheral pulses abnormal?	☐ Yes	☐ No	
b) Is there any evidence of heart enlargement?	☐ Yes	☐ No	
c) Are there murmurs or abnormal heart sounds?	☐ Yes	☐ No	
d) Do you suspect any abnormality of the cardiovascular system?	☐ Yes	☐ 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_____ 20 _____ at _____ a.m./p.m.

_____

Signature /Thumb impression of the Examinee

_____
Signature of the Introducer:
(Agent / Development Officer)
Name : _____
Code No. _____

_____
Signature of the Medical Examiner
Name: _____
Address: _____
Qualification: _____

Code No. : _____

_____

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

_____