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 :<br>Mother:<br>Sibling 1<br>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

_____