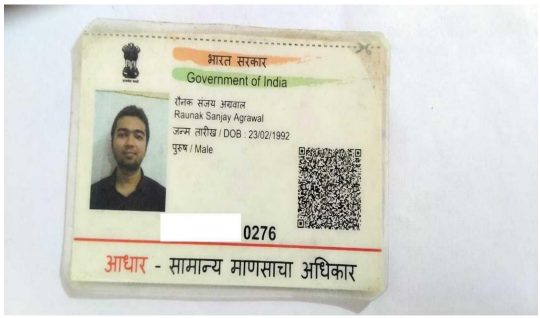
Face Match Score

Customer Name	TA Code	Score %
Raunak Sanjay Agrawal	WX971917	99.729537963867%

Photo Id



Reference Photo Id


Raunak
GPS Map Camera
Mumbai, Maharashtra, India
1, Yashodham, Goregaon, Mumbai,
Maharashtra 400063, India
Lat 19.16879°
Long 72.86876°
08/10/22 07:11 AM GMT +05:30
Google

भारत सरकार

Government of India

रौनक संजय अग्रवाल

Raunak Sanjay Agrawal

जन्म तारीख / DOB : 23/02/1992

पुरुष / Male

[redacted] 0276

आधार - सामान्य माणसाचा अधिकार

MAX LIFE INSURANCE

MAX LIFE INSURANCE CO. LTD.
Regd. Office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi – 110 020.
Head Office: 11th & 12th Floor, DLF Square, Jacaranda Marg, DLF City Phase-II, Gurgaon - 122002, Haryana

Medical Examination Report

PROPOSAL NUMBER	11596828	AGENT CODE	

A. IDENTIFICATION DETAILS OF EXAMINEE:

1. Name (First/Middle/Last)	Paurnali Agarwal					
2. Date of birth (DD/MM/YYYY)	23/04/1998					
3. Identification Proof		PAN		Driving License		Aadhar Card ✓
		Passport		Voter ID		Others (Please specify) _____
4. Identification Proof No.	0276			Mobile No.		
Email ID						

		Yes	No
A	Are you pregnant? (Applicable only for women)	N/A	
A11	If 'yes', then how many months?		
A12	Any pregnancy related complications?		
A13	Description of the problem:		
B	Have you undergone any of these tests like mammogram, ultrasound, pap smear etc.? (Applicable only for women) If 'yes', then please answer the below questions	N/A	
B11	Were the test reports normal? If 'no', then please provide details		
B12	Description of the problem:		
C	Do you have any history of chest pain, heart attack, palpitations or breathlessness on exertion or irregular heartbeat? If 'yes', then please answer the below questions		✓
C11	Chest pain was related to "Heart"		
C12	Chest pain was a result of "Muscular Pain"		
C13	Chest pain was a result of "Gastritis Problem"		
C14	Details of any other heart related problem:		
D	Do you have any hypertension / high blood pressure / high cholesterol? If 'yes', then please answer the below questions		✓
D11	Are you taking medicines for hypertension and is under control		
D12	Are you taking medicines for high cholesterol and is under control		
D13	In case of high BP or cholesterol, provide details:		
E	Do you have high blood sugar / diabetes, thyroid disorder, or any other endocrine disorders? If 'yes', then please answer the below questions		✓
E11	Are you a diabetic under treatment?		
E12	Are you under treatment for thyroid disorder and is it under control?		
E13	Any other disorder:		
F	Do you have asthma / bronchitis / wheezing / tuberculosis / breathing difficulties or any respiratory disorders? If 'yes', then please answer the below questions	✓	
F11	Do you take inhaler frequently for asthma / bronchitis?		✓
F12	Do you have a history of asthma with night symptoms and hospitalisation?		✓
F13	Do you have allergic bronchitis and use inhaler sometimes? H/O Allergic Asthma Since 2015. Inhaler Bosmat 503.		✓
F14	Do you have a history of asthma with symptoms appearing sometimes?		✓
F15	Do you have a history of tuberculosis in the past two years with no relapse?		✓
F16	Any other details:		✓

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		Yes	No
G	**Do you have any blood disorders such as anaemia, leukaemia, or any circulatory disorders? If 'yes', then please answer the below questions**		✓
G11	Do you have a history of iron deficiency anaemia which has now come back to normal?		
G12	If you have any other problem, then please share the details:		
H	**Do you have any liver disorders such as cirrhosis, hepatitis, jaundice, disorder of the stomach, colitis, or indigestion? If 'yes', then please answer the below questions**		✓
H11	Do you a history of jaundice which has now been cured after treatment?		
H12	Do you have any indigestion or constipation?		
H13	Do you have a history of gall bladder removed or cholecystectomy?		
H14	Do you have a history of stones in the gall bladder which currently has no complications?		
H15	Do you have a history of Hepatitis 'A' infection which has recovered?		
H16	Do you have a history of fatty liver grade 1?		
H17	Do you have a history of Hepatitis 'B' and 'C'?		
H18	If you had any other problem, then please share the details:		
I	**Do you have any physical or mental disability or any congenital disease? If 'yes', then please answer the below question**		—
I11	Details of the problem:		
J	**Do you have form of cancer, tumour, cyst, or growth of any kind of enlarged lymph nodes? If 'yes', then please answer the below question**		✓
J11	Details of the problem:		
K	**Do you have any diseases related to kidney failure, kidney or ureteric stones, blood, or puss in urine / prostate or gynaecological disorders? If 'yes', then please answer the below questions**		✓
K11	Do you have a history of surgery of kidney / ureteric stone which currently has no complications?		
K12	Do you have kidney stone which did not require a surgery as it was flushed out / caused no problem?		
K13	Do you have a history of Urinary Tract Infection (UTI) which you have recovered from?		
K14	Do you have a history of ovarian cyst which currently has no complications?		
K15	If you have any other problem, then please share the details:		
L	**Do you have epilepsy, nervous disorder, multiple sclerosis, tremors, numbness, paralysis or psychiatric disorder? If 'yes', then please answer the below questions**		✓
L11	Details of the problem:		
M	**Do you have any eye, ear, nose or throat related disorders (excluding the use of spectacles)? If 'yes', then please answer the below questions**		✓
M11	Have you undergone a sight related correction through glasses or LASIK?		
M12	Do you have a history of cataract surgery?		
M13	Do you have a history of cold, cough and sore throat?		
M14	Do you have a history of URTI (Upper Respiratory Tract Infection)?		
M15	Have you had a surgery of DNS (Deviated Nasal Septum)?		
M16	Do you have a history of sinusitis?		
M17	If you have any other problem, then please share the details:		
N	**Do you have any disorder of the back, muscle, joints, bone, neck, deformity, amputation, arthritis, or gout? If 'yes', then please answer the below questions**		✓
N11	Do you have a history of back pain due to slip disc with no complications currently?		
N12	Do you have a history of back pain or are you undergoing any sprain related physiotherapy / exercise?		
N13	Do you have a history of hairline fracture / any ligament tear with no problems currently?		
N14	Do you have a history of / currently have osteoarthritis / gout on Rx with no current problems as such?		
N15	Do you have a history of / currently have joint pain?		
N16	Do you have any history of fracture which you have recovered from now?		

		Yes	No
N17	If you have any other problems, then please share the details.		
O	In the last 5 years, have you had or been advised to have / in the next 30 days, will you have an X-ray / CT scan / MRI / ECG / TMT / blood test or any other investigatory or diagnostic tests / any type of surgery? If 'yes', then please answer the questions below and specify the date / reason / findings		✓
O11	Do you have a history taken after an accident?		
O12	Do you have a history or surgery after accident which you have recovered from now?		
O13	Do you have a history of appendix surgery?		
O14	Do you have a history of surgery for piles or haemorrhoids?		
O15	Do you have a history of MRI scan for back pain?		
O16	Do you have a history of gall stone / kidney stone?		
O17	Have you had a surgery for hernia?		
O18	Have you done tests during the annual preventive health check-up with normal results?		
O19	Have you done blood investigations for fever / flu / viral fever / malaria / typhoid / dengue with no complications currently?		
O20	Have you done blood tests / USG during pregnancy?		
O21	Do you have a history of blood test done for blood donation?		
O22	Have you undergone a surgery for insertion / removal of rods / screws?		
O23	If you have any other problem, then please share the details:		
P	Have you or your spouse tested positive / under treatment for HIV / AIDS / Sexually Transmitted Diseases (eg. Syphilis, gonorrhoea, etc.)? If 'yes', then please answer the below questions		✓
P11	Details of the problem:		
Q	Are you under treatment / medication, have received in the past or undergone a surgery / hospitalised for any medical condition / disability? If 'yes', then please answer the below questions		✓
Q11	Have you ever been hospitalised for fever?		
Q12	Have you ever been hospitalised for food poisoning?		
Q13	Have you ever been hospitalised after an accident?		
Q14	Have you ever been hospitalised for C-section / stone removal appendicectomy / piles / hernia?		
Q15	Have you ever been hospitalised for treatment of malaria / typhoid / dengue / gastroenteritis / dehydration?		
Q16	If you have any other problem, then please share the details:		
R	Have you been on leave at work due to illness / for a continuous period of more than 10 days in the last 1 year? If 'yes', then please answer the below questions		✓
R11	Do you have a history of surgery due to accident?		
R12	Have you been treated for tuberculosis more than 2 years ago?		
R13	Have you undergone a caesarean section?		
R14	Have you been on leave due to back pain / slip disc?		
R15	Have you been on leave due to joint pains?		
R16	Have you been treated for malaria / typhoid / dengue?		
R17	If you have any other problem, then please share the details:		
S	Have you suffered from / are suffering from any disease / ailment / habit which has not been mentioned above? If 'yes', then please share the details		✓
S11	Details of the problem:		
T11	Height (in centimetres) 173		
T12	Weight (in kilograms) 79		
U11	Blood pressure (reading to nearest 5mmHg) (If the first reading exceeds 140/90, two further readings should be taken after a 5 Minutes interval) Diastolic to be 5th phase i.e. Cessation of sound.		

		1st	2nd	3rd
	Systolic	118		
	Diastolic	76		

U12	Pulse (If over 90 please recount at the end of examination)						
	Rate	Rhythm	Quality	State of blood vessels	Comment on Ankle Pulse		
	72/-	Regular	Good	Normal	Equal		
						Yes	No
U13	Is Murmur present? If yes, give description?						✓
V	Habits and Addictions: Cigarettes / beedi / cigar; gutka / snuff / paan; beer / wine / hard liquor; drugs						✓
V11	Tobacco (Smoking / Chewing) currently or even occasionally in the last 1 year?						✓
V12	Have you been smoking more than 20 cigarettes a day or chewing more than 10 sachets of tobacco a day?						✓
V13	Alcohol (Beer, wine / hard liquor). If yes, then please answer the below questions						✓
V14	Do you drink any kind of alcohol more than 3 days a week?						✓
V15	Have you ever been advised to quit alcohol?						✓
V16	Have you been taking drugs like cannabis / marijuana / ecstasy / heroin / LSD / amphetamines or any other illegal drugs?						✓
W	Have you ever tested positive for SARS-COV-2/COVID-19 or are awaiting test results for such tests or been advised to be under quarantine OR in the last 2 months have suffered/currently suffering from fever, cough, sore throat, or flu like symptoms?					✓	
W11	Have you been vaccinated for COVID19?					✓	
W12	Full vaccinated	✓	Partially vaccinated				
W13	< 1 Week		>1 Week	✓			
W14	Have you experienced any complication post vaccination?						✓
W15	If yes, please share details including treatment taken for the same and date of complete recovery						✓

DECLARATION: I certify that after satisfying myself of the true identity of examinee, (i) have carefully examined the examinee, (ii) I have asked each question mentioned herein above in person / face-to-face, (iii) that the answers recorded above are exactly as given to me by the examinee and (iv) that this report has been signed by the examinee in my presence.

Name and Signature / Stamp of the Medical Doctor

Dr. Saumil .S.
MBBS
REG.NO. 2002/08/1704

Date: 08/10/2022

DECLARATION: I hereby declare (i) that the above answers are true, accurate and complete in all respects, (ii) that I have not withheld or suppressed any facts which may be relevant and material to enable the company to make an informed decision about the acceptability of the risk, (iii) that the above shall form a part of the application for the proposed insurance cover on my life and one of the factors on the basis of which the company may assume risk on my life and (iv) medicals will be considered invalid in case customer is associated with diagnostic centre.

Signature of Examinee: Saumil

Date: 08/10/2022

KJ CURE MEDICAL ENVIRONMENT

COVID-19 (Coronavirus) Exposure Questionnaire

Thank you for applying for a policy from Max Life Insurance Company Limited. To enable us to process your application, send this questionnaire duly answered and signed by the Life to be Assured and Proposed Policy Holder, wherever applicable, to be acknowledged, sections which are not relevant should be mentioned NA (Not applicable)

1. Have you ever tested positive for the coronavirus (SARS-CoV-2/COVID-19)? (If yes, please fill the Covid-19 questionnaire below)	Yes ☑ No ☐ • If yes then, when was SARS-CoV-2/COVID-19 diagnosed? ☑ <= than 1 month ☐ > 1-3 month ☐ > 3 months • Mode of treatment ☐ Hospitalized ☑ Home Quarantine/ Asymptomatic If Hospitalized is marked then, A. Did you require stay in: Select appropriate option. ☐ High-dependency unit (HDU) / Intensive care unit (ICU) / Critical care unit (CCU) / Ventilator ☐ Any other mode of stay _____

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- Please specify period of hospitalization: From DD/MM/YYYY _____ TO _____ DD/MM/YYYY
- Have you made a full physical function recovery from COVID-19? ☑ Yes ☐ No
- Recovery Period: ☑ <= than 1 month ☐ >1 -3 month ☐ >3 month
  Recovery date 5/3/21 (DD-MM-YYY)
- Treatment Received for SARS-CoV-2/COVID-19: Please select appropriate option (s)
  - ☑ No treatment
  - ☐ Oxygen therapy taken
  - ☐ Supported ventilation (e.g. High flow nasal oxygen, CPAP, BiPAP, helmet ventilation etc.)
  - ☐ Medication (pls specify name and doses) _____
  - ☐ Surgery (Pls specify name of surgery) _____
  - ☐ Investigations done (If Yes, mention name and result (normal / abnormal):
    Blood test: NO
    Chest X-ray: NO
    HRCT Thorax: (if yes, provide CT Score) NO

B. Whether you suffered Covid-19 related Complications? ☐ Yes ☑ No
If yes, then please select appropriate option(s):
- ☐ Lungs (e.g., pulmonary diseases-including pneumonia, embolism, acute/chronic respiratory failure etc.)
- ☐ Heart (e.g., Myocardial infarction, myocarditis, acute or chronic heart failure etc.)/ Stroke/ Hypertension)
- ☐ Kidney (e.g., Renal failure etc.)
- ☐ Diabetes (e.g., Newly diagnosed)
- ☐ Neurological symptoms/Mental issues (e.g., anxiety, depression, low mood, psychosis, lack of concentration, memory loss, seizures etc.)
- ☐ Septic shock
- ☐ Others (pls specify) _____
- ☐ NO complication

If answer to question W in medical examination report or question 1 is yes, then please provide all related prescriptions, records and medical reports. In case records are not available then kindly provide a declaration with a reason _____

I hereby declare and agree that the above particulars and answers are complete and true, that I have not held back any relevant facts or details, and that the answers to questionnaire will form part of the application for the desired insurance on my life.

Signature of life insured _____ Date: 08/10/2022

KJ CURE NURSING HOME

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Max Life Insurance Co. Ltd.: Plot No. 90A, Sector 18, Gurugram, Haryana - 122 015.
Regd. Office: 419, Bhai Mohan Singh Nagar, Railmajra, Tehsil Balachaur, District Nawanshahr, Punjab - 144 533.
Fax: 0124-4159397, CIN: U74899PB2000PLC045626 | Customer Helpline Number: 1860 120 5577
IRDAI Registration. No. 104