MAX LIFE INSURANCE CO. LTD

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Head Office: 11th & 12th Floor, DLF Square, Jacaranda Marg, DLF City Phase-II, Gurgaon-122002, Haryana

Medical Examination Report

PROPOSAL NUMBER ☐☐☐☐☐☐☐☐☐ **AGENT CODE** ☐☐☐☐☐☐

A. IDENTIFICATION DETAILS OF EXAMINEE:

1.Name(First/Middle/Last)

2.Date of birth (DD/MM/YYYY) Gender : ☐ Male ☐ Female

3.Identification Proof ☐ Pan ☐ Passport ☐ Driving License ☐ Voter ID ☐ Aadhaar Card ☐ Others (Please specify)...........................

4.Identification Proof No Mobile No

B. PERSONAL / MEDICAL HISTORY (To be asked by the Medical Examiner):

	Yes	No
1. **FOR FEMALE ONLY**- Are you pregnant? If yes, how many months	☐	☐
2. **FAMILY HISTORY**- Have any of your parents or siblings ever suffered from heart attack, hypertension, diabetes mellitus, cancer, kidney disease (excluding kidney stones), multiple sclerosis, or any other hereditary disorder? If yes, give details.	☐	☐

Family Member (Relationship)	Age at Diagnosis	Condition

3. HAVE YOU EVER BEEN INVESTIGATED, TREATED OR DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS. IF YES, PROVIDE DETAILS INCLUDING DOCTOR'S NAME AND DATES

		Yes	No
a.	Chest pain, heart attack, stroke, rheumatic fever, heart murmur, palpitation, shortness of breath or any other heart conditions.		
b.	Hypertension or high blood pressure.		
c.	Diabetes, thyroid disorder or any other endocrine disorders.		
d.	Asthma, bronchitis, tuberculosis, persistent cough, shortness of breath or any other respiratory conditions.		
e.	Blood disorder like anaemia, leukaemia or any circulatory disorder.		
f.	Liver disorders like cirrhosis, hepatitis, jaundice, disorder of the stomach, gall bladder or intestines, ulcer, colitis, gallstones, indigestion.		
g.	Any congenital disorder.		
h.	Cancer, tumour or growth (malignant or benign).		
i.	Kidney or bladder disorder, stones, prostate disorder or gynaecological disorder.		
j.	Epilepsy, nervous disorder, multiple sclerosis, tremors, numbness, double vision, paralysis, depression or psychiatric disorder.		
k.	Eye, ear, nose or throat disorder (Except use of spectacles).		
l.	Disorder of back, muscle, joints, bone, neck, deformity, amputation, arthritis or gout.		
m.	In the last 5 years, have you had or been advised to have or in the next 30 days will you have an X-ray/ CT Scan / MRI / Ultra sonography / ECG / blood test or any other investigatory or diagnostic tests or any type of surgery?		
n.	Have you ever been tested positive for HIV /AIDS or Hepatitis B or C or have you ever been tested /treated for sexually transmitted diseases?		
o.	Are you suffering from any illness other than those mentioned above or have undergone or are undergoing any kind of investigation / treatment?		
p.	Have you been off work due to illness or for a continuous period of more than 10 days during the last one year?		

DETAILS (Condition, date of onset, treatment, hospitalisation, surgery, recovery and physician details)

4. TOBACCO / ALCOHOL / DRUGS Consumption (IN CASE YOU CONSUME OR HAVE EVER CONSUMED)

Substance	Yes	No	Qty./ Day	For No. of Yrs
Tobacco (Stick / gms)- Panmasala/Cigar / Cigarette / Bidi / Gutkha	☐	☐		
Alcohol(ml)- Beer / Wine / Hard Liquor	☐	☐		
Drugs other than prescribed by Doctor - ganja / cocaine / cannabis / marijuana / ecstasy / heroin / LSD / amphetamines or other illegal drugs	☐	☐		

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 or details 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.

Date (DD/MM/YYYY)

Time

Signature of examinee **Signature of medical examiner**

(To be completed by the Medical Examiner)

NAME OF EXAMINEE

1. Has the examinee ever consulted you for any reason other than insurance examination? ☐ Yes ☐ No
2. What is the general appearance of the examinee?
3. Does the appearance correspond to the age stated? ☐ Yes ☐ No

4. **HEIGHT & WEIGHT INFORMATION**

Height	☐ ft ☐☐ Inch Or ☐ Mtr ☐☐☐ cm	Chest Circumference ☐☐☐ cm
Weight	☐☐☐ Kg	Abdominal circumference ☐☐☐ cm
Has your weight changed more than 5kg in the past one year? If yes, how many kgs.of loss/gain?	☐ Yes ☐ No ☐☐☐ Kg	
Reason for weight change		

5. **URINE DIPSTICK** (Not to be conducted if examinee is <12yrs old)

Protein ☐ Sugar ☐ Deposits ☐ Reaction ☐

6. **BLOOD PRESSURE** (readings 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.

(mm Hg)	First	Second	Third
Systolic			
Diastolic			

7. Pulse (If over 90 please recount at end of examination)

Rate	Rhythm	Quality	State of Blood Vessel	Comment on Ankle Pulse

8. Situation of Apex Beat:
9. Is murmur present? If yes, give description ☐ Yes ☐ No
10. Condition of any varicose veins (give description)
11. **Is there any evidence of past / present disease or disorder of the following:**

		Yes	No
a.	Brain or nervous system (include reflex, gait, paralysis, poliomyelitis, deformity, use of walking aid)	☐	☐
b.	Lungs or other parts of respiratory system	☐	☐
c.	Cyanosis, dyspnoea, oedema, CAD, Peripheral vascular disease, cardiac hypertrophy, cardiac failure or any other cardiovascular abnormality	☐	☐
d.	GI Tract (including hernia, any surgical scars)	☐	☐
e.	Ears, Eyes, Nose, Throat, Neck, Lymph nodes or other abnormal swellings	☐	☐
f.	Bones, Joints, Arteries, Veins or Skin (including amputation and reason for amputation)	☐	☐
g.	Genito-Urinary system	☐	☐
h.	Are there any tobacco stains, leukoplakia, oral thrush or signs of oral cancers	☐	☐
I.	Any other abnormal findings?	☐	☐

Details

In your opinion is there anything about the examinee's health, lifestyle, character or mode of life which might affect the insurability of the examinee?

DECLARATION

I certify that after satisfying myself of the true identity of the examinee, (i) I have carefully examined the examinee in private, (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.

Medical Examiner's Name **Qualification**		**Medical Examiner's sign and stamp** **Address**		**DATE** ☐☐ ☐☐ ☐☐☐☐ **TIME**