



Sahara India Life Insurance Company Limited

Sahara India Centre, 2, Kapoorthala Complex, Lucknow -226 024

Phone : (0522) 2337777, Fax : (0522) 2332683, Website : www.saharalife.com, Email : life@life.sahara.co.in

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IMPORTANT

1. Please satisfy yourself about the identity of the life proposed to guard against impersonation.
2. The life proposed and the person introducing him/her should sign on the Medical Report/Diary in your presence.
3. Please complete this Medical Report only after going through the replies given by the life to be assured in the completed proposal form.

MEDICAL EXAMINER'S REPORT

THIS MEDICAL EXAMINATION BE CONDUCTED IN PRIVATE AND NO OUTSIDE PERSON BE PRESENT

Introduced by Designation Signature 1. Name of the life to be examined a. Father /Husband's name b. Signature of the life to be examined c. Whether Identity verified Yes No Give Details 2. Are you in any way related to the Proposed Life or to the Agent? Yes No 3. Does his/her appearance indicate poor health? Yes No 4. Does he / she appear older than stated age? Yes No

5. Height in cms.	Weight in Kgs.	Girth of Abdomen in cms at Navel Level	Chest on inspiration in cms at Nipple Level	Chest on expiration in cms. at Nipple Level
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Do you have any reason to believe that the proposed assured is a higher than average risk for AIDS? If yes, give details. Yes No

7. Blood Pressure (If over 140 systolic or 90 diastolic or with history of hypertension, record 3 readings)	Systolic	mmHg	mmHg	mmHg
	Diastolic 5 th Phase	mmHg	mmHg	mmHg

8. Pulse at Rest, Rate per Minute Irregularities per minute

9. Do you find any evidence of past or present disease or abnormality of:

a. Respiratory system (lungs, pleura, chest wall, abnormal breath sounds) Yes No b. Central or peripheral nervous system (including reflexes, gait, paralysis) Yes No c. Genito-Urinary system (kidneys, urethra, bladder, prostate or reproductive organs) Yes No d. Gastro intestinal system Yes No e. Skin, bones, or joints (including varicose veins, deformities, lameness, amputations, scars) Yes No f. Eyes, ears, nose, throat and mouth including impairment of sight (power of glasses if applicable) or hearing Yes No g. Thyroid or other endocrine glands or metabolic and haemopoietic systems Yes No h. Lymphatic system Yes No 10. Is there any evidence of any operation, accident or injury? If so, please give full details. Yes No 11. Whether, any ECG, X-Ray Screening, Urine, Stool, Blood examination or any other diagnostic test was conducted? Yes No
If so, please give details.

12. Are the gums, teeth and tongue healthy? Yes No
13. Any hernia or varicose veins? Yes No
14. Do you suspect any abnormality in the heart or vascular system, hypertension, cardiac enlargement, cardiac failure, heart murmurs, abnormal heart sounds upon review of your overall findings? Yes No
15. Has any immediate family member ever suffered from or is suffering from heart or kidney disease, stroke, hypertension, diabetes, tuberculosis, mental disease or any other hereditary disease? Yes No
16. Are you aware of current or past consumption of tobacco / alcohol / drugs in any form? Yes No

If yes, ascertain the kind and amount of consumption per day?

17. Do you recommend any additional tests or reports? Yes No
- If any of the above questions are answered as "Yes", please give details.

18. For Female Applicants Only

- a. Is there any disease of the breast? Yes No
- b. Is there any evidence of pregnancy? Yes No
- c. Do you suspect any disease of uterus, cervix or ovaries? Yes No
- d. Is there any weakness or injury resulting from childbearing or miscarriage? Yes No

19. What is your general impression of the life to be assured after completing your medical examination?

20. Do you recommend the Life to be Assured for Insurance?

DECLARATION BY THE MEDICAL EXAMINER

I hereby certify that I have made this examination of the life to be assured personally in private and have recorded the findings as correct and true in my own hand writing to the best of my knowledge. I have made this examination in private at on the day of 200 at a.m. / p.m.

Signature of Medical Examiner	
Name of Medical Examiner	
Clinic Rubber Stamp of Medical Examiner	
Examiner's Medical Code No.	
Please enclose all the papers in an envelope and seal it and sign across the flap. Please do not hand these papers over to the Agent. You have to hand this over to the SILICL, LCO or to any of its official representatives only.	