



**MEDICAL EXAMINER'S CONFIDENTIAL REPORT**

1.	Full Name of the Life Assured			Policy No.					
	Identification Marks								
2.	Height (cms.) (without shoes)		Weight (kgs.) (In thin clothes)		Girth of abdomen(cms.) (over navel)				
	Chest (cms.) over nipple		Full Expiration (cms.)		Full Inspiration (cms.)				
	Pluse Rate p.m.		Blood Pressure		Systolic		Diastolic		
			1st Reading						
			2nd Reading						
3.	Is the general appearance healthy ?								
4.	Ascertain from the life to be assured whether at any time in the past he / she (i) has been hospitalised ? (ii) was involved in an accident ? (iii) has undergone any Radiological, Cardiological, Pathological or any other tests? (iv) is currently under any treatment ?								
	IF THE ANSWER TO ANY OF THE NEXT 9 QUESTIONS (QN. 5 TO 13) IS 'YES' PLEASE GIVE FULL DETAILS.								
5.	Is there any abnormality of the Cardiovascular system ?								
6.	Is there any swelling of joints, enlargement of thyroid, lymphatic glands or scars (of earlier surgery) ?								
7.	Is there any abnormality found on examination of Mouth, Ear, Nose, Throat or Eyes ?								
8.	Is there partial/total blindness or any other physical impairment ?								
9.	Are there any symptoms or signs suggesting abnormality or disease of the Respiratory system ?								

10.	Is there any evidence of enlargement of liver or spleen ?	
11.	Is there any abnormality in abdomen or abnormality of pelvis?	
12.	Is Hernia present ?	
13.	Is there any evidence of disease of Central or Peripheral Nervous System ?	
14.	Is there any evidence of operation ? If so, state a) The year of Operation b) Its nature and cause c) Its location, size and condition of scar d) Degree of impairment, if any	
15.	Is there any evidence of injury due to accident or otherwise? If so, state (i) the year in which the injury occurred (ii) nature of injury (iii) degree of impairment, if any (iii) duration of unconsciousness in case of head injury	
16.	Is there any other adverse feature in health or habit, past or present, which you consider relevant ? If so, give details.	
17.	<b>FOR FEMALE ONLY:</b> a) Is there any disease of the breasts ? b) Is there any evidence of pregnancy ? If so, give duration c) Do you suspect any disease of uterus cervix or ovaries ?	

I hereby certify that I have, this day, examined the above life assured personally, in private and recorded in my own hand (i) the true and correct findings. (ii) the answer to Question No. 4, as ascertained from the person examined.

I declare that the person examined signed (affixed his/her thumb impression) in the space earmarked below, in my presence and that I am not related to him/her or the Agent.

Dated at ..... on the ..... day of ..... 20..... at .....am/pm

Signature of the life to be assured

Signature of the Medical Examiner

Introduced by Name & Address	Medical Examiner's Name and Address
Designation	
Signature	