**KUESIONER ALKOHOL DAN**

**PENGGUNAAN OBAT-OBATAN**

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| Perlu diperhatikan:   1. Wajib diisi oleh (Calon) Pemegang Polis dan/atau (Calon) Tertanggung dengan tinta hitam, huruf cetak, jelas dan memberi tanda (√) pada kotak sesuai pilihan. 2. Wajib diisi Orang Tua (Calon) Tertanggung, apabila (Calon) Tertanggung berusia <21 Tahun. 3. Wajib menandatangani setiap koreksi penulisan (jika ada). 4. Penulisan tanggal selalu mempergunakan format Tanggal-Bulan-Tahun. 5. Apabila diperlukan dapat mempergunakan lembar terpisah pada kertas HVS A4 yang diisi dan ditandatangani oleh (Calon) Pemegang Polis, (Calon) Tertanggung dan Tenaga Penjual. 6. Apabila telah diisi lengkap oleh (Calon) Pemegang Polis dan/atau (Calon) Tertanggung wajib diserahkan ke Kantor Pusat PT Asuransi Jiwa BCA (“Penanggung”). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I. DATA (CALON) TERTANGGUNG | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | Nomor Surat Pengajuan Asuransi Jiwa:  (SPAJ)/Polis Asuransi | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 2. | Nama Lengkap (Calon) Tertanggung:  (sesuai dengan KTP/Paspor) | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 3. | Tempat, Tanggal lahir (Calon) Tertanggung: | | | | | | | | | | |  | | | | | | | | , |  |  | / |  |  | / |  |  |  |  |
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| II. WAJIB DILENGKAPI (CALON) TERTANGGUNG | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | Apakah saat ini Anda mengkonsumsi alkohol/obat-obatan? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon mengisi kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Jenis | | | | | | | | | | | | Frekuensi | | | | | Dosis | | | | | Waktu Penggunaan | | | | | | | |
|  | Mulai  (Tgl/Bln/Thn) | | | | Berhenti  (Tgl/Bln/Thn) | | | |
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|  | Alkohol | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Narkotika | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Amphetamine | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Ganja, marijuana | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Cocaine | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Halusinogen | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Penenang/obat tidur | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Zat tertentu (lem, thinner) | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Obat penghilang rasa sakit | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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|  | Lainnya, sebutkan ………………………………………………… | | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | | |
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| 2. | Jika Anda telah berhenti menggunakan alkohol/obat-obatan tersebut diatas.  (Mohon menjelaskan secara rinci pada kolom di bawah ini atas saran/permintaan siapa dan sejak kapan Anda berhenti). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3. | Apakah Anda pernah melakukan konsultasi atau mendapatkan terapi dari dokter karena penggunaan alkohol/obat-obatan? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Nama Dokter | | | | | | | | | Alamat | | | | | | | | | | | | | | Waktu Konsultasi | | | | | | |
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| 4. | Pernahkah Anda mengalami kondisi medis atau gangguan yang berhubungan dengan penggunaan alkohol/obat-obatan? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | (Misal hepatitis, HIV, kesehatan mental, dan lain-lain) | | | | | | | | | | | | |  |  | Ya | |  | Tidak | | |  |  |  |  |  |  |  |  |  |
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|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. | Apakah Anda menjalani perawatan di rumah sakit karena penggunaan alkohol/obat-obatan? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon mengisi secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | a. | Nama Dokter | | | | | : |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | b. | No. Telp/Hp | | | | | : |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | c. | Alamat Dokter | | | | | : |  | | | | | | | | | | | | | | | | | | | | | | |
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| 6. | Apakah Anda saat ini masih mendapatkan perawatan? | | | | | | | | | | | | | |  | Ya | |  | Tidak (Jika “Ya”, mohon mengisi kolom di bawah ini). | | | | | | | | | | | |
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|  | a. | Nama Dokter | | | | | : |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | b. | No. Telp/Hp | | | | | : |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | c. | Alamat Dokter | | | | | : |  | | | | | | | | | | | | | | | | | | | | | | |
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| 7. | Apakah Anda pernah tidak masuk kerja karena kondisi ini? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, kapan: | | | | | |  |  | / |  |  | / |  |  |  |  | Dan berapa lama: | | | | | | | |  | | | Hari | | |
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| 8. | Apakah pernah melakukan pemeriksaan kesehatan sehubungan penggunaan alkohol/obat-obatan? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon menjelaskan secara rinci dan berapa lama terjadinya pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 9. | Mohon Anda memberikan informasi tambahan lain yang menurut Anda penting mungkin dapat membantu proses pengajuan asuransi ini dengan melengkapi kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| PERNYATAAN DAN KUASA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Saya/Kami menyatakan bahwa Saya/Kami telah memahami dan menyetujui untuk mengisi secara lengkap dan benar semua informasi dalam Kuesioner Alkohol dan Penggunaan Obat-obatan ini sesuai dengan keadaan sebenarnya sebagai bagian dari kontrak asuransi Jiwa/Kesehatan/Kecelakaan. 2. Saya memberi kuasa kepada setiap Dokter/Rumah Sakit/Klinik/Puskesmas/Laboratorium, perusahaan asuransi atau perusahaan reasuransi, badan, instansi/lembaga atau pihak lain yang mempunyai catatan riwayat kesehatan Saya, untuk mengungkapkan kepada Penanggung mengenai semua keterangan tentang catatan riwayat kesehatan Saya. 3. Kuasa ini merupakan hal yang tidak terpisahkan dari SPAJ dan akan mengikat Saya, Penerima Manfaat/Ahli Waris, dan keluarga Saya (jika ada). 4. Kuasa ini tetap berlaku pada waktu Saya masih hidup maupun sesudah Saya meninggal dunia. Salinan/fotokopi dari surat kuasa ini sama sah berlakunya seperti dokumen asli. 5. Apabila informasi tersebut yang Saya/Kami berikan tidak benar, maka Penanggung berhak membatalkan Polis Saya/Kami sejak awal. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Ditandatangani: | | | | |  | | | | | | | | | | |  | Tanggal: | | | |  |  | / |  |  | / |  |  |  |  |
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| Nama Lengkap & Tanda tangan  (Calon) Pemegang Polis | | | | | | | | | |  | Nama Lengkap & Tanda tangan  (Calon) Tertanggung | | | | | | | | | |  | Nama Lengkap & Tanda tangan Tenaga Penjual | | | | | | | | |