**KUESIONER CEDERA**

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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 menandatangani setiap koreksi penulisan (jika ada). 3. Penulisan tanggal selalu mempergunakan format Tanggal-Bulan-Tahun. 4. Apabila diperlukan dapat mempergunakan lembar terpisah pada kertas HVS A4 yang diisi dan ditandatangani oleh (Calon) Pemegang Polis, (Calon) Tertanggung dan Tenaga Penjual. 5. 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. | Kapan terakhir kali mengalami cedera/kecelakaan? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. | Jelaskan penyebab cedera yang dialami.  (Bila kecelakaan lalu lintas, jelaskan posisi Anda sebagai pengemudi, penumpang, pejalan kaki atau lainnya) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3. | Apakah Anda sebelumnya pernah mengalami cedera/kecelakaan sejenis? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4. | Apakah Anda mengalami gangguan kesadaran (pingsan) akibat cedera/kecelakaan tersebut? | | | | | | | | | | | | | | | | | | | | | | | |  | 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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| 5. | Apakah Anda memerlukan perawatan di rumah sakit/perawatan gawat darurat? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, kapan: | | | | | |  |  | / |  |  | / |  |  |  |  | Dan berapa lama? | | | | | | | |  | | | Hari | | |
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|  | Nama Lengkap Dokter: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | No. Telepon/Handphone: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | Nama Klinik/Rumah Sakit: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | Alamat Klinik/Rumah Sakit: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| 6. | Jelaskan secara rinci pada kolom di bawah ini jenis dan hasil pemeriksaan kesehatan yang dilakukan sehubungan dengan cedera atau kecelakaan ini, termasuk tanggal pemeriksaannya. (*Lampirkan fotokopi hasil pemeriksaan*) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 7. | Jelaskan secara rinci pada kolom di bawah ini bagian tubuh yang mengalami cedera, serta jenis luka yang didapatkan (luka lecet/patah tulang dan sebagainya)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 8. | Apakah Anda pernah dioperasi atau dianjurkan operasi untuk cedera ini? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, kapan: | | | | | |  |  | / |  |  | / |  |  |  |  | Dan berapa lama? | | | | | | | |  | | | Hari | | |
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|  | Nama Lengkap Dokter: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | Nama Klinik/Rumah Sakit: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | Alamat Klinik/Rumah Sakit: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| 9. | Apakah Anda telah sembuh dari cedera? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Ya, kapan gejala terakhir dialami? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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|  |  | Tidak, keluhan apa yang dialami saat ini? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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|  |  | Jika “Tidak”, mohon mengisi kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | a. | Nama Dokter | | | | | | | | : |  | | | | | | | | | | | | | | | | | | |
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|  |  | b. | Alamat Dokter | | | | | | | | : |  | | | | | | | | | | | | | | | | | | |
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|  |  | c. | Seberapa sering Anda kontrol | | | | | | | | : |  | | | | | | | | | | | | | | | | | | |
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|  |  | d. | Kapan kontrol terakhir Anda | | | | | | | | : |  | | | | | | | | | | | | | | | | | | |
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| 10. | Apakah Anda pernah tidak masuk kerja karena cedera ini? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, kapan: | | | | | |  |  | / |  |  | / |  |  |  |  | Dan berapa lama? | | | | | | | |  | | | Hari | | |
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| 11. | 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 Cedera 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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