**KUESIONER EPILEPSI DAN KEJANG**

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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. | Sejak umur berapa Anda terserang epilepsi? | | | | | | | | | | | | | | |  | | | | Tahun | | |  | | | |  | | | |
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| 2. | Berapa kali Anda terserang epilepsi? | | | | | | | | | | | | | | |  | | | | kali per (Bulan/Tahun\*) \*coret yang tidak perlu | | | | | | | | | | |
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| 3. | Kapan terakhir kali Anda terserang epilepsi? | | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  | | | |
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| 4. | Pada saat Anda terserang epilepsi, apakah: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Hanya hilang kesadaran sejenak tanpa kaku-kaku, kemudian lupa dengan apa yang telah terjadi. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Tiba-tiba jatuh atau kaku-kaku pada seluruh tubuh dengan irama kaku-lemas-kaku secara bergantian, juga terjadi pada otot-otot wajah dengan mulut berbusa. Dan pada saat terjadi kedua kaki dan lengan lurus, kesadaran hilang dan bila berakhir, kemudian tertidur. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. | Sebelum terjadi serangan, apakah Anda merasakan adanya pusing-pusing, mencium bau-bauan, melihat cahaya, atau | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | bunyi-bunyian? | | | | | | |  | Ya | |  |  | Tidak | |  |  |  | |  |  |  | |  |  |  |  |  |  |  |  |
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|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6. | Apakah Anda pernah dirawat karena epilepsi? | | | | | | | | | | | | | | | | | | | | | |  |  |  | Ya | |  | Tidak | |
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| 7. | Apakah Anda selalu berkonsultasi/berobat ke Dokter? | | | | | | | | | | | | | | | | | | | | | |  |  |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon melengkapi kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Nama Lengkap Dokter : | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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|  |  | No. Telepon/Handphone : | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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|  |  | Alamat Lengkap Dokter : | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| 8. | Kapan terakhir kali Anda berkonsultasi dengan dokter? | | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  | | | |
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|  | Apakah Anda mendapat obat dokter? | | | | | | | | | |  |  | Ya | |  |  | Tidak | | (Jika “Ya”, mohon mengisi kolom di bawah ini). | | | | | | | | | | | |
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|  | Nama Obat | | | | | | | | | | | | | | Dosis | | | | | | | | Frekuensi | | | | | | | |
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| 9. | Apakah Anda masih minum obat secara teratur hingga saat ini? | | | | | | | | | | | | | | | | | | | | | |  |  |  | Ya | |  | Tidak | |
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| 10. | Apakah Anda pernah menderita penyakit infeksi selaput otak/gegar otak sebelumnya? | | | | | | | | | | | | | | | | | | | | | |  |  |  | Ya | |  | Tidak | |
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| 11. | Apakah ada riwayat keluarga Anda yang menderita epilepsi? | | | | | | | | | | | | | | | | | | | | | |  |  |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 12. | Apakah Anda menderita penyakit lain seperti di bawah ini: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Kencing Manis (Diabetes Melitus) | | | | | | | | | | | |  | Darah Tinggi (Hipertensi) | | | | | | | | | | | | | | | |
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|  |  | Tumor | | | | | | | | | | | |  | Penyakit komplikasi lainnya, sebutkan …………………………………………………….….. | | | | | | | | | | | | | | | |
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|  | Mohon mengisi Kuesioner sesuai dengan penyakit lainnya yang Anda derita sesuai dengan pilihan pada nomor 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 13. | Apakah Anda pernah melakukan pemeriksaan berikut? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Elektroensefalografi (rekaman syaraf otak) | | | | | | | | | | | |  | Rontgen photo tengkorak (kepala) | | | | | | | | | | | | | | | |
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|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 14. | 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 Epilepsi dan Kejang 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 | | | | | | | | |