**KUESIONER GANGGUAN PENCERNAAN**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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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. | Gangguan pencernaan yang pernah Anda alami? | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Tukak Lambung | | | | | |  | Tukak Usus | | | | | |  | Radang Usus Besar | | | | | |  | Radang Usus 12 Jari | | | | | |  |  |
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|  |  | Maag | | | | | |  | Lainnya, sebutkan ………………………………………………………………………… | | | | | | | | | | | | |  |  | | | | | |  |  |
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|  | Mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. | Sejak kapan Anda mengalami gangguan pencernaan? | | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  | | | |
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| 3. | a. | Berapa kali Anda terserang gangguan pencernaan? | | | | | | | | | | | | | |  | | | kali per (bulan/tahun\*) \*coret yang tidak perlu | | | | | | | | | | | |
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|  | b. | Kapan timbulnya keluhan terakhir? | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |
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| 4. | Keluhan apa yang Anda dirasakan? | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Mual | | | | | |  | Muntah | | | | | |  | Muntah Darah | | | | | |  | Nyeri Ulu Hati | | | | | |  |  |
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|  |  | Lainnya, sebutkan ………………………………………………………………………… | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 5. | a. | Apakah Anda pernah mengalami muntah darah? | | | | | | | | | | | | | |  | Ya | |  | Tidak | | |  |  |  |  |  |  |  |  |
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|  | b. | Jika “Ya”, kapan terakhir Anda mengalaminya? | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |
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|  | c. | Berapa kali Anda mengalami muntah darah? | | | | | | | | | | | | | |  | | | kali per (bulan/tahun\*) \*coret yang tidak perlu | | | | | | | | | | | |
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|  | Mohon menjelaskan secara rinci dan cara mengatasinya pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6. | Jelaskan secara rinci keluhan nyeri yang Anda dirasakan: | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Timbul pada kondisi tertentu, jelaskan: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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|  |  | Nyeri berkurang bila sedang makan | | | | | | | | |  | Nyeri bertambah bila sedang makan | | | | | | | | | | |  |  | | |  |  | | |
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|  |  | Nyeri menjalar ke seluruh tubuh lain: | | | | | | | | |  | Kepala | | |  | Dada | | |  | Perut | | |  | Lengan | | |  |  | | |
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| 7. | Mohon jelaskan secara rinci pada kolom di bawah ini mengenai nama obat yang Anda konsumsi dan lama pemakaiannya sehubungan dengan gangguan pencernaan? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 8. | Apakah obat yang Anda peroleh tersebut berdasarkan resep dokter? | | | | | | | | | | | | | | | | |  |  | Ya | |  | Tidak | | |  |  |  |  |  |
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|  | Jika “Ya”, mohon menjelaskan secara rinci (nama obat, dosis dan frekuensi penggunaannya) pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Nama Obat | | | | | | | | | | | | | | Dosis | | | | | | | | Frekuensi | | | | | | | |
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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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| 9. | Mohon jelaskan secara rinci pada kolom di bawah ini jenis dan hasil pemeriksaan kesehatan yang dilakukan sehubungan dengan gangguan pencernaan ini, termasuk tanggal pemeriksaannya. (*Lampirkan fotokopi hasil pemeriksaan*) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 10. | Apakah Anda pernah mendapatkan perawatan Rumah Sakit sehubungan dengan gangguan pencernaan tersebut? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Ya | |  | Tidak | | |  | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Jika “Ya”, sejak kapan: | | | | | |  |  | / |  |  | / |  |  |  |  | s/d | |  |  | / |  |  | / |  |  |  |  |  |  |
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|  | Lama perawatan: | | | | | |  | | | (bulan/tahun\*) \*coret yang tidak perlu | | | | | | | | | | | | | | | | | | | | |
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|  | a. | Nama Dokter | | | | | | | : |  | | | | | | | | | | | | | | | | | | | | |
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|  | b. | Alamat Dokter | | | | | | | : |  | | | | | | | | | | | | | | | | | | | | |
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| 11. | Apakah Anda sampai saat ini masih dalam pengobatan? | | | | | | | | | | | | | | |  | Ya | |  | Tidak | | |  |  |  |  |  |  |  |  |
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|  | Jika “Ya”, mohon menjelaskan secara rinci (nama obat, dosis dan frekuensi penggunaannya) pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Nama Obat | | | | | | | | | | | | | | Dosis | | | | | | | | Frekuensi | | | | | | | |
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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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| 12. | Dalam 2 tahun terakhir ini, apakah Anda pernah tidak masuk kerja karena gangguan ini? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, kapan: | | | | | |  |  | / |  |  | / |  |  |  |  | Dan berapa lama? | | | | | | | |  | | | Hari | | |
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| 13. | 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 Gangguan Pencernaan 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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