**KUESIONER GANGGUAN PERNAPASAN**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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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. | Apakah gangguan pernapasan yang Anda derita? | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Asma | | | | | |  | TBC | | | | | | |  | Bronchitis | | | | | | | |  |  | | | | |
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|  |  | Lainnya, sebutkan ………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. | Kapan pertama kali Anda merasakan gejala-gejala tersebut? | | | | | | | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |
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| 3. | a. | Berapa kali serangan dalam 2 (dua) tahun terakhir? | | | | | | | | | | | | | |  | | |  | | |  |  |  |  |  |  |  |  |  |
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|  | b. | Kapan serangan terakhir? | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |
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| 4. | Berapa kali serangan-serangan tersebut menyebabkan Anda:  (Mohon melampirkan resume perawatan yang Anda miliki) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Tidak masuk kerja, selama: | | | | | | |  | | Hari | | |  |  | | Minggu | | |  |  | | Bulan | | |  |  | | Tahun | |
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|  |  | Dirawat di Rumah Sakit | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Tanggal perawatan: | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Lama perawatan: | | | | | | | |  | | | (hari/minggu/bulan\*) \*coret yang tidak perlu | | | | | | | | | | | |  |  |  |  |  |  |
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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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| 5. | Sewaktu tidak ada serangan, apakah ada keluhan-keluhan berikut? | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |
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|  |  | Batuk | | | | | |  | Napas pendek | | | | | | |  | Berbunyi “ngik” | | | | | | | |  |  | | | | |
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| 6. | a. | Pengobatan apakah yang digunakan untuk mengatasi gangguan pernapasan? | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |
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|  |  |  | Inhaler | | | |  | Obat-obatan (Jelaskan nama obat, dosis dan frekuensi penggunaannya pada kolom di bawah ini). | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Nama Obat | | | | | | | | | | | | | | | | | Dosis | | | | | | Frekuensi | | | | | |
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|  | b. | Kapan obat-obatan tersebut konsumsi? | | | | | | | | | | | | | | | | |  | Setiap hari | | | |  | Hanya saat serangan | | | | | |
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|  | c. | Apakah obat-obatan tersebut masih digunakan sampai sekarang? | | | | | | | | | | | | | | | | |  | Ya | | |  |  | Tidak | | | |  |  |
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|  |  | Mohon menjelaskan alasannya secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 7. | Sehubungan dengan gangguan pernapasan, kapan dan bagaimana hasil pemeriksaan darah, rontgen dada, spirometri lainnya? (Mohon dilampirkan fotokopi hasil pemeriksaan). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 8. | Mohon lengkapi data Dokter dan Rumah Sakit yang biasa dikunjungi untuk gangguan pernapasan. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Tanggal terakhir konsultasi: | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Diagnosa: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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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 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 Pernapasan 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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