**KUESIONER GANGGUAN TULANG BELAKANG**

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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 Anda pernah menderita hernia/spondylosis/kelainan tulang belakang lainnya? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. | Kapan pertama kali keluhan tersebut dirasakan? | | | | | | | | | | | | | | | |  |  | | / |  |  | / |  |  |  | |  |  |  | | | |
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| 3. | Seberapa seringkah keluhan tersebut timbul dalam 12 bulan terakhir? | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| 4. | Mohon menjelaskan secara rinci pada kolom di bawah ini dan pada bagian tubuh mana? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. | Apakah aktivitas Anda mengalami hambatan? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6. | Kapan mengalami hambatan? | | | | | | | | | | | | | | | |  |  | | / |  |  | / |  |  |  | |  |  |  | | | |
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| 7. | Mohon menjelaskan secara rinci pada kolom di bawah ini menurut Dokter apa penyebab diagnosis gangguan tulang belakang tersebut? (Kecelakaan, Proses penuaan, kecelakaan sewaktu berolahraga, dan sebagainya). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 8. | Apakah Anda pernah menjalani X-ray, MRI, atau pemeriksaan lainnya? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon berikan tanggal pemeriksaan: | | | | | | | | | | | | |  |  | / |  |  | | / |  |  |  |  |  |  | |  |  |  |  |  |  |
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|  | Mohon jelaskan secara rinci pada kolom di bawah ini hasil pemeriksaan kesehatan yang dilakukan sehubungan dengan gangguan tulang belakang ini. (*Lampirkan fotokopi hasil pemeriksaan*) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 9. | Apakah Anda menggunakan tongkat untuk berjalan atau alat bantu lainnya? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 10. | Apakah Anda pernah dioperasi atau dianjurkan operasi untuk kelainan ini? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, mohon berikan tanggal operasi: | | | | | | | | | | | | |  |  | / |  |  | | / |  |  |  |  |  |  | |  |  |  |  |  |  |
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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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| 11. | Mohon jelaskan dengan rinci jenis pengobatan Anda saat ini dan dahulu pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Apakah diberi suntikan? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Tanggal Berobat | | | | | | Nama Obat | | | | | | | | | | | | Dosis | | | | | | | | Frekuensi | | | | | | |
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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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| 12. | Saat ini dengan Dokter siapa Anda melakukan kontrol? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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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| 13. | Seberapa sering Anda kontrol? | | | | | | | | | |  | | | kali per (hari/minggu/bulan/tahun\*) \*coret yang tidak perlu | | | | | | | | | | | | | | | | | | | |
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| 14. | Kapan terakhir kali Anda kontrol? | | | | | | | | | | | | |  |  | / |  |  | | / |  |  |  |  |  |  | |  |  |  |  |  |  |
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| 15. | Apakah Anda pernah tidak masuk kerja dalam jangka waktu lama karena kondisi ini ? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, kapan: | | | | | | |  |  | / |  |  | / |  |  |  |  | Dan berapa lama? | | | | | | | | | |  | | | Hari | | |
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| 16. | 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 Tulang Belakang 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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