**KUESIONER KELAINAN KELENJAR GONDOK (TIROID)**

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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 pertama kali Anda mendapatkan gangguan pada kelenjar gondok (tiroid)? | | | | | | | | | | | | | | | | | | | | | |  |  | / |  | |  | / |  |  |  |  |
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| 2. | Apa diagnosa Dokter untuk gangguan kelenjar gondok (tiroid) Anda? | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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|  |  | Hipertiroidisme | | | | | | | | | |  | Hipotiroidisme | | | | | | | | | |  | Tiroiditis | | | | | | | | | |
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|  |  | Penyakit Hashimoto | | | | | | | | | |  | Goiter | | | | | | | | | |  | Penyakit Grave | | | | | | | | | |
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|  |  | Lainnya, sebutkan ………………………………………………………………………………………………………. | | | | | | | | | | | | | | | | | | | | |  |  |  |  | |  |  |  |  |  |  |
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| 3. | Mohon melengkapi pada kolom di bawah ini dengan data Dokter dan tempat Anda konsultasi? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Tanggal terakhir konsultasi | | | | | | | | | | | | |  |  | / |  |  | | / |  |  |  |  |  |  | |  |  |  |  |  |  |
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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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| 4. | Apakah Anda pernah atau saat ini sedang mengkonsumsi obat sehubungan kelainan kelenjar gondok (tiroid)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Ya | |  | Tidak | | | | (Jika “Ya”, mohon mengisi kolom di bawah ini). | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Tanggal Berobat | | | | | | Nama Obat | | | | | | | | | | | | Dosis | | | | | | | | Frekuensi | | | | | | |
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|  |  |  |  |  |  |  | |  |  | Tanggal | | | | | | | Keterangan | | | | | | | | | | | | | | | | |
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|  | Kapan pengobatan dimulai | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | Kapan pengobatan dihentikan | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | Mohon jelaskan secara rinci pada kolom di bawah ini alasan pengobatan diberhentikan. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Mohon jelaskan secara rinci pada kolom di bawah ini jika ada pengobatan lainnya. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. | Apakah Anda pernah melakukan pemeriksaan medis sehubungan kelainan kelenjar gondok (tiroid)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Ya | |  | Tidak | | | | (Jika “Ya”, mohon melengkapi hasil pemeriksaan pada kolom di bawah ini). | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Jenis Pemeriksaan | | | | | | | | | Tanggal | | | | | | | Hasil | | | | | | | | | | | | | | | | |
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|  | T3 | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | T4 | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | TSH | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | ECG | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | Biopsi | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | Scan/MRI/USG | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
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| 6. | 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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|  | Lama perawatan di Rumah Sakit: | | | | | | | | | | | | |  | | | Hari | | | |  |  |  |  |  |  | |  |  |  |  |  |  |
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|  | Jenis 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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|  | Mohon melampirkan hasil Patologi Anatomi operasi tersebut | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Ada | |  | Tidak | |
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|  | Jika “Tidak”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Menurut Dokter Anda, bagaimana hasil Patology Anatomi tersebut? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Jinak | | | |  | | Ganas | | | |  | Lainnya, sebutkan ………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | |
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| 7. | Apakah ada pengobatan atau tindakan yang dilakukan setelah operasi? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | 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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|  |  |  |  |  |  |  | |  |  | Ya | | | Tidak | | | Keterangan | | | | | | | | | | | | | | | | | |
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|  | Obat | | | | | | | | |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |
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|  | Radioterapi | | | | | | | | |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |
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|  | Kemoterapi | | | | | | | | |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |
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|  | Lainnya | | | | | | | | |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |
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| 8. | 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 Kelenjar Gondok (Tiroid) 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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