**KUESIONER DIABETES MELITUS**

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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 diketahui menderita diabetes? | | | | | | | | | | | | | | | | | | |  |  |  | / |  |  | / |  |  |  |  |
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| 2. | a. | Berapa kali frekuensi kontrol ke dokter? | | | | | | | | | | | | | |  | | | | kali per | | |  | | | | Minggu | | | |
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|  | b. | Mohon melengkapi kolom di bawah ini dengan nama dan alamat lengkap dokter yang biasa dikunjungi untuk kontrol? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Nama Dokter | | | | | | | | | | Alamat Dokter | | | | | | | | | | | Tanggal Pemeriksaan Terakhir | | | | | | | |
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|  | c. | Pengobatan apa saja yang Anda diperoleh? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  | Insulin | | |  | | | | unit/hari | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  | Diet khusus, jelaskan | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  | Oral/tablet. | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  | Mohon menjelaskan secara rinci pada kolom di bawah ini (nama obat, dosis, frekuensi penggunaan dan lain-lain). | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3. | a. | Bagaimana frekuensi melakukan pemeriksaan kadar gula dalam urine? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  | Setiap hari | | | | | |  | Setiap minggu | | | | | |  | Setiap bulan | | | | | |  | Tidak pernah | | | | | |  |
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|  | b. | Kapan terakhir melakukan pemeriksaan kadar gula dalam urine? | | | | | | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Bagaimana hasilnya? | | | | | |  | + | |  |  | ++ | |  |  | +++ | |  |  | ++++ | |  |  |  |  |  |  |  |  |
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|  | c. | Mohon melengkapi kolom di bawah ini dengan hasil 3 (tiga) pemeriksaan terakhir? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Jenis Pemeriksaan | | | | | | | | I | | | | | | | II | | | | | | | III | | | | | | |
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|  |  | Kadar gula darah | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | |
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|  |  | Tanggal pemeriksaan terakhir | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | |
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|  | d. | Apakah pernah didapatkan adanya protein/albumin dalam test urine? | | | | | | | | | | | | | | | | | | |  | Ya | | |  | Tidak | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | e. | Apakah dilakukan pemeriksaan glycosylated haemoglobin (HbA1c)? | | | | | | | | | | | | | | | | | | |  | Ya | | |  | Tidak | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4. | Apakah pernah mengalami perawatan di rumah sakit karena diabetes? | | | | | | | | | | | | | | | | | | | |  | Ya | | |  | Tidak | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Jika “Ya”, mohon melengkapi kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Alasan Perawatan | | | | | | | Nama Dokter | | | | | | Alamat Dokter | | | | | | | Tanggal Perawatan | | | | | Jangka Waktu Perawatan | | | | |
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| 5. | Apakah kondisi Diabetes Mellitus ini disertai komplikasi organ lain sebagai berikut? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Gangguan penglihatan | | | | | | | | | | | |  | Tekanan darah tinggi | | | | | | | | | | | | | | | |
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|  |  | Gangguan ginjal dan/saluran kemih | | | | | | | | | | | |  | Gangguan sensorik, termasuk kebas dan panas di kaki | | | | | | | | | | | | | | | |
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|  |  | Kelainan darah | | | | | | | | | | | |  | Koma diabetikum | | | | | | | | | | | | | | | |
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|  |  | Gangguan jantung dan/pembuluh darah | | | | | | | | | | | |  | Lainnya, sebutkan …………………………………………… | | | | | | | | | | | | | | | |
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| 6. | 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 Diabetes Melitus 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 | | | | | | | | |
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