**KUESIONER TEKANAN DARAH TINGGI**

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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. | a. | Kapan pertama kali Anda mengetahui menderita tekanan darah tinggi? | | | | | | | | | | | | | | | | | |  |  |  | / |  |  | / |  |  |  |  |
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|  | b. | Berapa tekanan darah Anda saat itu? | | | | | | | | | | | | | | / | | | | | | | | | mmHg | | |  |  |  |
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|  | c. | Mengapa Anda saat itu melakukan pemeriksaan tekanan darah? | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  | Pemeriksaan Rutin | | | | |  |  |  | Keluhan Lainnya (mohon jelaskan secara rinci pada kolom di bawah ini). | | | | | | | | | | | | | | | | | | | |
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|  | d. | Apakah dikonsultasikan ke Dokter? | | | | | | | | | | |  | Ya | |  |  | Tidak | | |  |  |  |  |  |  |  |  |  |  |
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|  |  | Jika “Ya”, mohon mengisi kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  | Nama Lengkap Dokter | | | | | | | | : |  | | | | | | | | | | | | | | | | | | |
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|  |  |  | Alamat Lengkap Dokter | | | | | | | | : |  | | | | | | | | | | | | | | | | | | |
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|  | e. | Berapa sering Anda kontrol ke Dokter? | | | | | | | | | |  | | | | | kali per (hari/minggu/bulan/tahun\*) \*coret yang tidak perlu | | | | | | | | | | | | | |
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| 2. | Apakah kenaikan tekanan darah Anda tersebut berhubungan dengan penyakit sebagai berikut: | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |
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|  |  | Jantung | | | |  | Otak | | |  | Ginjal | | |  | Lainnya, sebutkan …………………………………………………………………………………………………… | | | | | | | | | | | | | | | |
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| 3. | a. | Kapan Anda memulai pengobatan kenaikan tekanan darah tersebut? | | | | | | | | | | | | | | | | | |  |  |  | / |  |  | / |  |  |  |  |
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|  | b. | Apakah Anda pernah berhenti minum obat? | | | | | | | | | | | | | |  |  | Ya | | |  | Tidak | | |  |  |  |  |  |  |
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|  |  | Jika “Ya”, mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | c. | Apakah Anda saat ini masih dalam pengobatan? | | | | | | | | | | | | | |  |  | Ya | | |  | Tidak | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 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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| 4. | Apakah Anda pernah melakukan pemeriksaan sebagai berikut? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | EKG/ ECG | | | | |  | Rontgen dada | | | | |  | Echocardiogram | | | | |  | Treadmill | | | | |  | Laboratorium | | | | |
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|  |  | Lainnya, sebutkan ............................................................................................. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Mohon menjelaskan secara rinci pada kolom di bawah ini.  (Kapan dan bagaimana hasilnya serta melampirkan fotokopi hasil pemeriksaan). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. | Apakah Anda pernah mendapat perawatan rumah sakit sehubungan dengan tekanan darah tinggi? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | 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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| 6. | Apakah tekanan darah tinggi yang Anda derita disertai disertai komplikasi organ lain sebagai berikut? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Tidak ada | | | | | |  |  |  |  | Ginjal | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Otak | | | | | |  |  |  |  | Gangguan Penglihatan | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Hati | | | | | |  |  |  |  | Lainnya, sebutkan ………………………………………………………………………… | | | | | | | | | | | | |  |  |  |  |  |  |
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| 7. | Jelaskan rata-rata tekanan darah dalam 12 (dua belas) bulan terakhir (termasuk tanggal pemeriksaannya) pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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 Tekanan Darah Tinggi 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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