**KUESIONER TUMOR**

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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 lembar tambahan, dapat mempergunakan Formulir Pernyataan/Amandemen Untuk SPAJ & Pengajuan Pelayanan Polis 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 adanya tumor? | | | | | | | | | | | | | | | | | | | |  |  | / |  |  | / |  |  |  |  |
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| 2. | Pada bagian tubuh mana tumor tersebut tumbuh? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3. | Mohon sebutkan diagnosis pasti dari tumor tersebut. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4. | Apakah tumor tersebut telah diangkat/dioperasi? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | a. | Tanggal operasi: | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | b. | Metode operasi (anestesi local, bedah beku/*cryosurgery*, operasi dengan anestesi umum, dan sebagainya).  Mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | c. | Mohon lengkapi data Dokter dan Rumah Sakit yang biasa dikunjungi untuk gangguan tumor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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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|  | d. | Pengobatan/tindakan apa yang diberikan setelah dilakukan operasi tumor? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  | Obat tablet | | | |  | Radioterapi | | | |  | Kemoterapi | | | |  | Lainnya, sebutkan ……………………………………………………………………….. | | | | | | | | | | | | |
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|  |  | Mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | e. | Apakah Anda pernah diberi informasi tentang prognosa (ramalan) atas tumor tersebut? | | | | | | | | | | | | | | | | | | | | | |  |  | Ya | |  | Tidak | |
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|  |  | Mohon menjelaskan secara rinci pada kolom di bawah ini. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | f. | Pemeriksaan-pemeriksaan apa saja yang telah dilakukan, termasuk tanggal dan hasil pemeriksaan tersebut. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Jenis Pemeriksaan | | | | | | | | | | Tanggal Pemeriksaan | | | | | | Hasil Pemeriksaan | | | | | | | | | | | | |
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|  | g. | Pengobatan atau tindakan operasi apa saja yang pernah dianjurkan? | | | | | | | | | | | | | | | | | | | | | |  |  |  | |  |  | |
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| 5. | Apakah sampai saat ini masih dalam pengobatan? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Tanggal terakhir perawatan: | | | | | | | | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Alasan | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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|  | Pengobatan: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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|  | Berapa kali dalam 1 (satu) tahun: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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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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| 6. | Apakah Anda pernah tidak masuk kerja karena kondisi ini? | | | | | | | | | | | | | | | | | | | | | | | |  | Ya | |  | Tidak | |
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|  | Jika “Ya”, kapan: | | | | | |  |  | / |  |  | / |  |  |  |  | Dan berapa lama? | | | | | | | |  | | | Hari | | |
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| 7. | Sebutkan kapan terakhir kali Anda melakukan konsultasi dengan dokter?  Mohon lengkapi pertanyaan pada kolom di bawah ini dan mohon dilampirkan fotokopi hasil pemeriksaan. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Jenis Pemeriksaan | | | | | | | | | | | Tanggal Pemeriksaan | | | | | | Hasil Pemeriksaan | | | | | | | | | | | | |
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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 Tumor 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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