

# Tour and Care Insurance Application for Tourists in Israel

Please fill out this form fully and accurately.

08/2021 Edition



I the undersigned (hereinafter, the "Insurance Applicant") ask of "Harel" Insurance Company Ltd. (hereinafter, the "Insurer") to insure me, based on all the content of this Application. The policy documents will be sent to your mobile phone number available to the Harel Company. If you wish to receive these documents by e-mail, you should fill in your e-mail address with the personal details. Alternatively, if you want to receive these document by Israel Post, please note this ..... (the documents will be sent according to the most recent details that appear in our files at the time of sending).

Agent's name: .....

Agent's number: .....

Insurance Period Requested	
From date	To date

Attn.  
Harel Insurance Company Ltd.  
Foreign Employees / Tourists Insurance Section  
3 Abba Hillel Street, PO. Box 1951, Ramat-Gan 5211802,  
Fax: 03-7348083 email: fax7930@harel-ins.co.il

This Form is designed for men and women alike.  
Please make sure that you fill out this Form accurately and completely.  
08/2021 Edition

Attn.  
Harel Insurance Company Ltd. - Foreign Employees / Tourists Insurance Branch  
3 Abba Hillel St., PO. Box 1951, Ramat Gan 5211802, Fax: 03-7348083 email: fax7930@harel-ins.co.il

## A Personal information of insurance applicants (up to the age of 75 years)

	Main Insured	Spouse	Child 1	Child 2	Child 3
Passport number					
Country of passport issuance					
First Name					
Last name					
Date of birth					
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of entry to Israel					
Citizenship					
Purpose of visit					
Address where you are staying in Israel	Street	House No.	Apartment No.	Town	
Mobile phone					
Last name of your host					
E-mail for personal notifications and mailings	.....@.....				

StudioHarel 31920.49 08/2021

## B Provider selection

Harel's private arrangement  Maccabi Health Services [HMO]



**C Health Statement**

The Health Statement below shall apply severally to each one of the following: the main Insured, the spouse and each one of the children insured. Please answer the questions below by marking (✓) in the column of the correct answer. If the answer to any of the questions is "Yes", you must attach an up-to-date report from the attending physician regarding the stated problem, test results, the manner of treatment and the current condition.

Is the purpose of the trip for one or more of the travelers is to receive a medical care?	Main Insured		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

If the answer to Question 1 is yes, we cannot accept you in the insurance.

Section A: General Questions		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	<input type="checkbox"/> Do you use, or have you been using narcotics? <input type="checkbox"/> Do you drink, or have you been drinking alcoholic beverages regularly? Please specify the quantity of consumption: ..... glasses per day.										
2.	During the last 5 years, have you been referred to any of the following examinations (other than as part of routine checkups) and not yet taken it, or not yet had a final diagnosis determined for you, such as: chronic illnesses, catheterization, bone mapping, echocardiography, MRI, CT, ultrasound (other than as part of routine prenatal care), biopsy, occult blood, colonoscopy or gastroscopy, autoimmune diseases including lupus (if "Yes", please submit a certificate from the attending physician, stating the reason for performing the examination, the examination outcomes and final diagnosis).										
3.	Are you now, or have you been sometime during the last 5 years, about to undergo a surgery / transplantation? Please describe in details: .....										
4.	During the last 5 years, have you been hospitalized? Please describe in details the reason for hospitalization and the treatment that you have received.										
5.	During the last 5 years, have you been taking, or have you received a recommendation to take, medications regularly? Please describe in details the problem for which you are treated / have been treated, the treatment, and for how long have you been taking the said medication?										
6.	Have you been diagnosed as suffering from any allergies? Please describe in details: .....										

Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	<input type="checkbox"/> The nervous system <input type="checkbox"/> Cerebrovascular accident (stroke) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Muscular dystrophy or other atrophic disease <input type="checkbox"/> Reoccurring dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Balance disorders <input type="checkbox"/> Fainting <input type="checkbox"/> Parkinson's syndrome <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Trembling <input type="checkbox"/> Mental retardation <input type="checkbox"/> Autism <input type="checkbox"/> Down's syndrome <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Poliomyelitis (infantile paralysis) <input type="checkbox"/> Gaucher's disease <input type="checkbox"/> Loss of sensation (numbness) <input type="checkbox"/> Attention deficit disorders <input type="checkbox"/> Migraine <input type="checkbox"/> Have you applied to a physician with complaints regarding declined memory (dementia) <input type="checkbox"/> AIDS <input type="checkbox"/> HIV carrier <input type="checkbox"/> Lupus If the answer to one or more of the questions above is "Yes", please attach an up-to-date letter from the attending neurologist.										
2.	<b>Eyes and vision:</b> <input type="checkbox"/> Cataract <input type="checkbox"/> Retina and cornea problems <input type="checkbox"/> Glaucoma <input type="checkbox"/> Inflammations of the eye <input type="checkbox"/> Strabismus <input type="checkbox"/> Blindness Other eye disease / problem: <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: .....										

**C Health Statement - continue**

Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3.	<b>Heart:</b> <input type="checkbox"/> Cardiac arrhythmias <input type="checkbox"/> Heart disease <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Catheterization <input type="checkbox"/> Heart valve diseases, other heart disease / problem: <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
4.	<b>Blood vessels:</b> <input type="checkbox"/> Varicose vein (in the veins of the legs) <input type="checkbox"/> Carotid artery (in the arteries of the neck) <input type="checkbox"/> Coagulation disorders <input type="checkbox"/> Blood disease DVT (Thrombosis) <input type="checkbox"/> PVD (Peripheral Vascular Disease), other vascular disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
5.	<b>Metabolic diseases:</b> <input type="checkbox"/> Thyroid gland <input type="checkbox"/> Lymph node <input type="checkbox"/> Salivary gland <input type="checkbox"/> Sweat gland <input type="checkbox"/> Pituitary gland <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> High levels of fats/cholesterol, other metabolic disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
6.	<b>Respiratory system:</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) <input type="checkbox"/> Hay fever <input type="checkbox"/> Recurrent respiratory infections and Shortness of breath <input type="checkbox"/> Collapsed lung (Pneumothorax) <input type="checkbox"/> Cystic Fibrosis Other respiratory system disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
7.	<b>Digestive system:</b> <input type="checkbox"/> Ulcer (duodenum / gastric) <input type="checkbox"/> Heartburn <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Reflux <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Fissure / Fistula <input type="checkbox"/> Bowel obstruction <input type="checkbox"/> Pancreatic diseases / infections <input type="checkbox"/> Esophagus <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gall-bladder stones Other digestive system disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
8.	<b>Liver:</b> <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis B, C, D <input type="checkbox"/> Fatty liver <input type="checkbox"/> Cirrhosis, other digestive system disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
9.	<b>Hernia:</b> Location of the hernia: In the diaphragm / in the navel / in the right groin / in the left groin Have you undergone a surgery to treat the hernia? <input type="checkbox"/> No <input type="checkbox"/> Yes, when (date)? ..... Is the problem solved? <input type="checkbox"/> No <input type="checkbox"/> Yes										
10.	<b>Kidney and urinary tract:</b> <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Kidney and urinary stones <input type="checkbox"/> Kidney cysts <input type="checkbox"/> Anomalies of urinary tract <input type="checkbox"/> Renal failure, other kidney and urinary tract disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
11.	<b>Joints and bones:</b> <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back / spine <input type="checkbox"/> Joints <input type="checkbox"/> Knees Other joints and bones disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
12.	<b>Skin and sex diseases:</b> <input type="checkbox"/> Skin tumors <input type="checkbox"/> Skin lesions <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> Syphilis Other skin and sex diseases disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify: ..... .....										
13.	Malignant tumors / diseases (cancer).										

**C Health Statement - continue**

Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
14.	<b>For women:</b> <input type="checkbox"/> Breasts (including breast enlargement) <input type="checkbox"/> Gynecological system, disease / other feminine problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:..... <input type="checkbox"/> Have you undergone a cesarean delivery? <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify when (date): .....										
15.	<b>For men:</b> <input type="checkbox"/> Prostate problems <input type="checkbox"/> Varicocele / Hydrocele Other masculine disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:.....										
16.	<b>Nose, ear and throat diseases:</b> <input type="checkbox"/> Sleep apnea syndrome <input type="checkbox"/> Nasal polyp <input type="checkbox"/> Sinusitis Other nose, ear and throat disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:.....										

Please specify (only if you answered "yes" to one of the questions in the Statement): .....

.....

.....

For your information - the policy does not provide coverage for a pre-existing medical condition.

**D Rider for Extra Insurance Fees**

Supplemental coverage	Main Insured	Spouse	Child 1	Child 2	Child 3
Medical air transportation					







## E Insurance Applicant's Statement

1. a. The information included in this document is required for your joining the policies and for all other matters and issues pertaining to the policies and the handling thereof. The Company and other companies of the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) and/or anyone on their behalf will make use of it, including the processing, storage and use thereof, for any matter pertaining to the policies and for other legitimate purposes, including by providing the information to third parties acting in the name and on behalf of the Harel Group.
- b. I/we hereby declare that all the answers are correct and complete and are provided out of my/our own free will.
- c. The answers specified in the Health Statement and any other information to be submitted to the Company as well as the Company's customarily prevailing terms and conditions in this matter shall be essential terms, conditions of the insurance contract between you and the Company, and constitute an inseparable part thereof.
- d. The Company may decide to either accept or reject the Application. For your information, the insurance contract shall come into force only after the Company issues a written confirmation of admission of all the insurance applicants.
- e. This consent and statement, including the Health Statement above, shall also apply to the children whose names are listed in the Application and your signature/s on the documents is made also in their names as their guardian.  
Are you authorized to sign these documents on their behalf?  Yes  No.
- f. I hereby confirm that I received essential information regarding the insurance, which included, at the very least, a description of the main elements of the coverage, the insurance premium, the insurance period, the main insurance amounts and the main limitations of liability, and regarding my possibility of obtaining full details about them.

### For your information:

2. Preexisting medical condition: an insurance event, substantially caused by the normal course of a preexisting medical condition, which occurred to the Insured during the period in which a restriction applies. A restriction because of a preexisting medical condition, concerning an insured whose age at the beginning of the insurance period is:
  1. Less than 65 years - Shall apply for a period not exceeding one year from the beginning of the insurance period.
  2. 65 years or more - Shall apply for a period not exceeding half a year from the beginning of the insurance period.
3. This medical insurance is subject to a qualification period of 48 hours.
4. I am aware that the insurance contract shall come into force only after the Company issues a written confirmation of admission regarding the Insurance Applicant. In any case, the insurance period shall begin from the date of confirmation by the Insurer, as said above.
5. **Consent to Use of Information**  
I agree, beyond the requirements arising from the law or an agreement, that the information included in this document, as well as additional information about me that is held or will be held by other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) will also serve the companies in the Harel Group and/or parties on their behalf for any purpose related to the other products and services of the companies in the Harel Group (in the area of insurance, long-term savings and finances) and its business partners and in their marketing, including to enable said companies to notify me of information about products and services, and for additional uses that accompany the above-said uses and are necessary to complete them, this also by means of providing the information to third parties that act in the name of and on behalf of the Harel Group.  
 Yes  No
6. **Waiver of medical confidentiality:** I/we the undersigned hereby give permission to an HMO (kupat holim) and/or its medical institutions and/or the IDF, and all the physicians and/or psychiatrists, the other medical institutions and hospitals, the National Security Council (MALAL) and/or the Ministry of Defense and/or any insurance company and/or to any other institution and entity, **insofar as required in order to inquire and settle claims according to the policy and/or for the purpose of the procedure for examining my acceptance to the requested insurance plan** to provide Harel including any information held by the Company and details with no exception and in the form required by those requesting it, about my/our health condition, about any illness I/we had in the past and/or that I/we are ill with now and/or will be ill with in the future and I/we release you from the duty of maintaining medical confidentiality and waiver this confidentiality towards the "requestor." This waiver binds me/us, my/our estate and my/our legal representatives and anyone that appears in my/our place. This waiver will also apply to my/our minor children.
7. By enrolling in this policy, you are authorizing your insurance agent in the policy to submit and to receive on your behalf/and for you all notices and/or documents related to the underwriting and policy enrolment processes.

### Insurance Applicant's Signature

	Date	Name of Insured	ID No.	Signature
Main Insured				
Spouse				
Child over the age of 18 years				
Child over the age of 18 years				
Child over the age of 18 years				
Witnessed the signing (the insurance agent)				
	Date	ID	Full name	Signature

**F Agent's Declaration (required clause that the agent must sign)****Agent's Statement of Compliance with Instructions of the Insurance Commissioner's Circular on the Matter of Joining an Insurance Plan:**

I confirm that in the process of selling the products specified in this Form of Joining, I complied with all the instructions of the Commissioner of Insurance in the Matter of Joining an Insurance Plan, and specifically, I inquired about the needs of the candidates, I proposed insurance and/or additional coverage, a rider or a service letter to the existing insurance policy that meet/s his/her/their needs and I gave him/her/them all the essential information required.

Date: ..... Name of agent: ..... Signature of agent:  .....

**G Payment by credit card - according to the arrangement of the Insured/Payer with the credit card company****Personal information of Insurance applicant**

First name	Last name	Passport No.
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**Personal information of Payer**

ID No.	Cardholder's name
CVV number (3 digits on the back of the card)	Valid until ..... / .....
	Card number


**You can pay in several installments depending on the period**

Number of days	1 to 90	91 to 181
Number of payments	1	1 <input type="checkbox"/> 2 <input type="checkbox"/>

Postal code	City	House No. and Street
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Email address: .....@.....	Telephone
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For your information, the means of payment will be used to pay the insurance fees for all those insured under the policy/ies. The amounts and dates of charges will be according to the Company's determination, according to the terms of payment of the insurance policy/ies and the changes made to them from time to time.

Date: .....	Name of credit card holder: .....	Credit card holder's signature  .....
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