

Health Statement for Medical Insurance - Foreigners in Israel



Subject to the Insurance Application attached hereto, which is inseparable part of the Health Statement.

This Form is designed for men and women alike.

Please make sure that you fill out this Form accurately and completely.

06/2024 Edition

Attn.

Harel Insurance Company Ltd. - Foreign Employees / Tourists Insurance Branch

3 Abba Hillel St., P.O. Box 1951, Ramat Gan 5211802, Fax: 03-7348083 email: fax7930@harel-ins.co.il

(סופס למועמד לביטוח)

A Particulars of the Insurance Applicant

Passport No.	Last Name	First name	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
--------------	-----------	------------	---------------	--

In this Health Statement you should answer the following questions by marking "✓" on the column of the appropriate answer. If the answer to any of the questions is "Yes" you have to attach an up-to-date certificate from the attending physician, addressing the stated problem, test results, the manner of treatment and the current status.

Section A: General Questions

	Yes	No
1. Height in cm: Weight in kg:		
2. <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.		
3. During the last 10 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).		
4. Are you now, or have you been sometime during the last 10 years, about to undergo a surgery / transplantation? Please describe in details:		
5. During the last 10 years, have you been hospitalized? Please describe in details the reason for hospitalization and the treatment that you have received.		
6. During the last 10 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?		
7. Have you been diagnosed as suffering from any allergies? Please describe in details:		

Section B: Have you been diagnosed with any illness, syndrome, disorder related to one or more of the issues specified below:

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. Eyes and vision: <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:		
3. Heart: <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. Blood vessels: <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:		



dt33539

A Particulars of the Insurance Applicant

Section B: Have you been diagnosed with any illness, syndrome, disorder related to one or more of the issues specified below:		Yes	No
5.	Metabolic diseases: <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.	Respiratory system: <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.	Digestive system: <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.	Liver: <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.	Hernia: 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.	Kidney and urinary tract: <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.	Joints and bones: <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.	Skin and sex diseases: <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).		
14.	For women: <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"/> Are you pregnant? <input type="checkbox"/> Have you undergone a cesarean delivery? <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify when (date):		
15.	For men: <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.	Mental illnesses: Mental illness that was diagnosed by a psychologist, psychiatrist or family physician.		
17.	Nose, ear and throat diseases: <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 provide details:

B Details of previous insurance policies

Have you ever been insured by Harel or any other insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes				
If yes, indicate company and the policy number/health care provider membership number:				
Insurance period		Company name	Policy No.	Membership No.
From	To			

C Power of Attorney of Agent

I hereby authorize my insurance agent for the Policy, Mr./Ms., to handle any matter regarding the Policy, including but not limited to the process of inclusion in the Policy, underwriting procedures, renewal or extension of the Policy for additional periods, submission of claims, changes and other actions in the Policy and so forth, in my name and for me. This includes submitting all correspondence and/or documents related to the above-said matters to "Harel" and receiving them from "Harel. I hereby give you my consent that the insurance agent serve as my delegate in any matter regarding the Policy and my permission to send the insurance agency all the details required by him, in any action related to the Policy, including details of other Policies with which I am insured at Harel, which are not necessarily policies in which the insurance agent to whom I give power of attorney in this agreement of mine is the attending agent.

.....
Date Name Signature of the Insured

For your information, copies of the correspondence and/or the documents related to the claim will in any case be sent to the your insurance agent for the policy.

D Declaration of Insurance Candidate

1. I, the undersigned, hereby request of Harel Insurance Company Ltd. (herein: "the Insurer/Company/Harel") to insure me based on the said in this proposal.
 - (a) Although it is not legally required that you provide some of the information requested in this document, the information is essential to adding you to the policies and handling matters related to them. The information will be collected, maintained and processed by the Company and other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) and third parties that operate for them and/or on their behalf will use them for the purpose of handling the policy and for other legitimate purposes, including actuary calculations. Additional details can be found in the privacy policy on the Company website.
 - (b) I hereby declare that all the answers are correct and complete and have been provided of my own free will.
 - (c) The answers specified in the Health Declaration and any other information provided to the Company, as well as the customary terms of the Company regarding this matter shall serve as fundamental terms of the insurance contract between you and the Company and shall constitute an integral part thereof.
2. **Beneficiaries in case of death**
 You may appoint beneficiaries, using the form "Application for update / Change of beneficiaries in case of death". In the absence of beneficiary appointment, the amounts will be paid to the legal heirs under the law, according to inheritance or probate order.
3. **Procedure of Joining:** The company is permitted to decide whether to accept or deny the proposal. For your information, the insurance contract will become effective only after the Company issues written confirmation of acceptance of the candidate for insurance. If further processing requires the clarification of terms, underwriting and acceptance for insurance, the policy shall not be issued for the insurance candidate and shall not become effective until completion of the procedures for the insurance candidate.
4. (a) I authorize my insurance agent for the policy, whose details appear at the beginning of this proposal, to submit to Harel and to receive from Harel in my name and for me all notices and/or documents related to the process of underwriting and the process of joining this policy.
 (b) I agree that the insurance policy of the insurance plans requested in this proposal be delivered to me by means of the agent whose details appear at the beginning of this proposal.
 (c) If you wish to receive the policy and/or the information in the framework of the underwriting procedure and the procedure of joining this policy directly, as well, you may contact Harel at any time, by phoning Harel (*2735).
5. 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.

6. Agreement to Use of Information and Receipt of Advertising Material	no	yes
---	----	-----

(a) Do you agree, beyond the requirements of the law or agreement, that the information included in this document, as well as additional information about you that is or will be possessed by other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) will be used by the Harel Group and/or anyone on their behalf, including for any matter related to the other products and services of the companies in the Harel Group (in the field of insurance, long-term savings and finances) and in their marketing, including allowing the said companies to inform you of products and services, and also for the purpose of handling other policies and/or insurance products, long-term savings and financing that you hold, processing and storing the information, and also for additional uses associated with the above-said uses and required in order to complete them, and for other related legitimate purposes, including by means of transferring the information to third parties acting on behalf of and in the name of the Harel Group.		
---	--	--

(b) We hereby inform you that there is a possibility that you will receive from the Company or from other companies in the Harel Group to which your details are provided (insofar as you consented to providing them with your details), marketing offers and advertising materials about products and services of the company and/or the companies in the Harel Group, as relevant, by means of fax, email, an automatic dialing system or short message service (SMS) texts. If you do not agree to receive marketing offers and advertising material as said, you may inform us of your refusal or change a previous choice at any time using the "Refusal of Advertising and Marketing Offers Form" which is available on the Company website at www.hrl.co.il/pirsum or by contacting us in writing at the address: Harel Building, Health Division, Personal Overseas and Foreign Resident Health Division, 3 Aba Hillel, POB 10951, Ramat Gan 5252202, or by calling: 03-7547777. Additional information about the privacy policy of the institutional bodies of the Harel Group is found on the Group website at www.harel-group.co.il		
--	--	--

7. Has any insurance company ever dismissed or canceled your health insurance application? No Yes, if "Yes" please specify:

8. **Waiver of medical confidentiality:** I, the undersigned, hereby grant permission to the HMO and / or its medical institutions, as well as to all physicians and / or psychiatrists, the medical institutions and other hospitals, and / or any insurance company and / or any other institution and entity, to the extent necessary to clarify the rights and obligations under the Insurance Policy, and / or for the purposes of reviewal procedure of my admission to the insurance sought, to submit to Harel, including any information held by the company and details without exception and in the form required by the Requesting Party(s), about my health condition, any illness that I have had in the past and / or currently have and / or will have in the future, and I release you from the duty to maintain medical confidentiality and waive this confidentiality in favor of the "Requesting Party". This waiver in writing obligates my legal estate and my legal representatives as well as anyone who will come in my stead.

The Insurance Candidate has signed this Health Condition Statement Form after having received an explanation of its content in a language in which he / she is fluent.

Date Signature of Insurance Candidate Signature of witness