

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.

05/2020 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

A Particulars of the Insurance Applicant

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



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:

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B Statement of the Insurance Applicant

1. I hereby declare that all answers are correct, complete and given voluntarily.
2. The answers given in the Health Statement and any other information to be provided to the Insurer as well as the terms and conditions accepted by the Insurer in this regard shall serve as a material condition of the insurance contract between you and the Insurer and will form an inseparable part thereof.
3. The Insurer may decide on accepting or rejecting the Application without having to justify its decision. Please note that the insurance contract comes into effect only after the Insurer issues a written confirmation of the Insured's admission to the insurance and after the initial Insurance Premium has been paid in full. This condition of payment of the full initial Insurance Premium will not apply if the Insurer has received a means of payment from which the Insurance Premium may be collected.
4. The information contained in this document is necessary for your admission to the Policies and for any other matter related to, and handling of, the Policies. The Company and other companies in the Harel Group (Harel Investments in Insurance and Financial Services Ltd. and its subsidiaries) and / or anyone on their behalf will use it, including its processing, storage and use for any issue that is related to the Policies and other legitimate purposes, even by way of transfer of the information to third parties operating in the name and on behalf of the Harel Group.
5. Has any insurance company ever dismissed or canceled your health insurance application? No Yes, if "Yes" please specify:
6. **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 

C Confirmation of admission terms and conditions

I give my consent, in advance, that as far as it becomes clear, during the underwriting process concerning me, that in order to produce the requested Insurance Policy, the underwriting terms and conditions set out below are required to be stipulated within the Insurance Policy which will be issued for me as applicable, then:

No coverage will be provided for an Insurance Event related to:

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Date

Name

Passport No.

Signature