

# Tour and Care Insurance Application for Tourists in Israel



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

09/2022 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

## 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	.....@.....				

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## B Provider selection

Harel's private arrangement  Maccabi Health Services [HMO]  Clalit 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.

Part A: Have you been diagnosed with an illness, condition, or disorder related to one or more of the issues specified below:	Main Insured		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Muscular dystrophy or another degenerative disease <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Recurring dizziness <input type="checkbox"/> Balance disorders <input type="checkbox"/> Fainting <input type="checkbox"/> Parkinson's <input type="checkbox"/> Alzheimer's* <input type="checkbox"/> Mental retardation* <input type="checkbox"/> Autism* <input type="checkbox"/> Down's syndrome* <input type="checkbox"/> Cerebral palsy* <input type="checkbox"/> Polio <input type="checkbox"/> Gaucher disease* <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Attention deficit disorder <input type="checkbox"/> Have you seen a doctor for complaints related to loss of memory in the last 3 years? <input type="checkbox"/> Another problem with the nervous system - <b>Send a detailed medical certificate</b>										
2. <input type="checkbox"/> AIDS and/or HIV carrier <input type="checkbox"/> Lupus										
3. <b>Eyes and vision:</b> <input type="checkbox"/> Cataract <input type="checkbox"/> Retinal problems <input type="checkbox"/> Corneal problems <input type="checkbox"/> Glaucoma <input type="checkbox"/> Eye inflammations <input type="checkbox"/> Strabismus <input type="checkbox"/> Blindness <input type="checkbox"/> Other eye disease/problem										
4. <b>Heart:</b> <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Cardiac defects <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Catheterization or bypass surgery <input type="checkbox"/> Vascular diseases <input type="checkbox"/> Other heart disease/problem										
5. <b>Blood vessels:</b> <input type="checkbox"/> Varices in veins of leg <input type="checkbox"/> Carotid artery stenosis <input type="checkbox"/> Clotting disorders <input type="checkbox"/> Anemia <input type="checkbox"/> Blood disease <input type="checkbox"/> DVT (thrombosis) <input type="checkbox"/> PVD (peripheral vascular disease)										
6. <b>Metabolism:</b> <input type="checkbox"/> Thyroid gland <input type="checkbox"/> Lymph gland <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 fat/cholesterol <input type="checkbox"/> Other metabolic disease/problem										
7. <b>Respiratory:</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis in past with full recovery <input type="checkbox"/> Active tuberculosis at present <input type="checkbox"/> COPD (chronic symptomatic lung disease) <input type="checkbox"/> Hay fever <input type="checkbox"/> Recurrent infection of respiratory airways and shortness of breath <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Other disease/problem of respiratory airways										
8. <b>Digestive system:</b> <input type="checkbox"/> Ulcer (stomach or duodenum) <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"/> Intestinal blockage <input type="checkbox"/> Pancreatic diseases/infections <input type="checkbox"/> Esophagus <input type="checkbox"/> Gall bladder <input type="checkbox"/> Gall stones <input type="checkbox"/> Other disease/problem of the digestive system?										
9. <b>Liver:</b> <input type="checkbox"/> Hepatitis B, C, D <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Fatty liver <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Other liver disease/problem										
10. <b>Hernia:</b> <input type="checkbox"/> In diaphragm <input type="checkbox"/> In umbilicus <input type="checkbox"/> In right groin <input type="checkbox"/> In left groin <input type="checkbox"/> At site of surgical scar <input type="checkbox"/> In abdominal wall										
11. <b>Kidneys and urinary tract:</b> <input type="checkbox"/> Recurring infections, stones in kidneys or urinary tract <input type="checkbox"/> Cysts in kidneys <input type="checkbox"/> Defects in urinary tract <input type="checkbox"/> Renal failure <input type="checkbox"/> Other disease/problem of kidneys and urinary tract										

\*The question is addressed only to the parent or guardian of an Insurance Candidate who is a minor or legally incompetent.

**C Health Statement - continue**

Part A: Have you been diagnosed with an illness, condition, or disorder related to one or more of the issues specified below:

		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
12.	<b>Joints and bones:</b> <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back/spine <input type="checkbox"/> Knees <input type="checkbox"/> Thighs <input type="checkbox"/> Shoulders <input type="checkbox"/> Joints <input type="checkbox"/> Decline in bone density <input type="checkbox"/> Other disease/problem of joints and bones										
13.	<b>Skin and Sex:</b> <input type="checkbox"/> Skin tumors <input type="checkbox"/> Skin damage <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sexual diseases <input type="checkbox"/> Syphilis <input type="checkbox"/> Other skin disease/problem <input type="checkbox"/> Other sexual disease										
14.	Malignant tumors*/ Malignant diseases (cancer) - if yes, is the disease or tumor active and/or diagnosed and/or treated in the past two years? <input type="checkbox"/> yes <input type="checkbox"/> no										
15.	<b>For women:</b> <input type="checkbox"/> Benign breast cysts or tumor <input type="checkbox"/> Breast augmentation <input type="checkbox"/> Fibrocystic breasts <input type="checkbox"/> Benign uterine cyst/tumor <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Cervical diseases (CIN) <input type="checkbox"/> Benign ovarian cyst/tumor <input type="checkbox"/> Polycystic ovaries <input type="checkbox"/> Benign cyst/tumor in Fallopian tubes <input type="checkbox"/> Recurring miscarriages <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Have you undergone childbirth by Caesarian section? <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Other problem with gynecological system or breasts?										
16.	<b>For men:</b> <input type="checkbox"/> Prostate problems <input type="checkbox"/> Varicocele <input type="checkbox"/> Hydrocele <input type="checkbox"/> Other men's disease/problem										
17.	<b>Mental illnesses diagnosed by a psychologist, psychiatrist or family physician:</b> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other mental illness										
18.	<b>Ear, nose and throat:</b> <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Polyp in nose <input type="checkbox"/> Sinusitis <input type="checkbox"/> Recurring throat infections <input type="checkbox"/> Vocal cord nodules <input type="checkbox"/> Adenoid <input type="checkbox"/> Enlarged nasal concha <input type="checkbox"/> Snoring <input type="checkbox"/> Deviated septum <input type="checkbox"/> Hearing impairment/deafness <input type="checkbox"/> Acoustic neuroma (tumor in auditory canal) <input type="checkbox"/> Torn eardrum <input type="checkbox"/> Tinnitus <input type="checkbox"/> Other ear-nose-throat disease/problem										
19.	Have you been diagnosed as suffering allergies?										

**Part B: General Questions**

		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
20.	Do you use or have you used drugs? If yes - <input type="checkbox"/> Hashish <input type="checkbox"/> marijuana <input type="checkbox"/> grass <input type="checkbox"/> cannabis Other drug .....										
21.	Do you or have you regularly drunk alcoholic beverages in a quantity of more than 2 glass a day?										
22.	Have you been referred for and not yet completed a process of investigation of a phenomenon or disease in the past two years <b>for which no final diagnosis has been determined?</b> (type of tests: mammogram, bone scan, catheterization, heart scan, echocardiogram, CT, MRI, ultrasound - not as part of prenatal monitoring, biopsy, occult blood, colonoscopy, gastroscopy, colposcopy)										
23.	Have you undergone surgery in the past 5 years or has it been recommended that you undergo surgery/transplant due to a disease/phenomenon/problem that you did not specify in one of the previous questions? Please provide details .....										
24.	Have you been hospitalized in the past 3 years due to a disease/phenomenon/problem that you did not specify in one of the previous questions? Please provide details .....										
25.	Have you taken medication or been recommended to take medication in the past 5 years for a disease/phenomenon/problem that you did not specify in one of the previous questions? Please provide details .....										

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 Confirmation of conditions for acceptance**

I agree in advance that insofar as it emerges in the underwriting procedure for me and/or for my child up to the age of 18 that provision of the coverages requested requires the following underwriting conditions, these will be set forth in the Policy issued to me and/or my child up to the age of 18, as relevant

An insurance event related to ..... will not be covered.

**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				 .....

**E Rider for Extra Insurance Fees**

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






## F 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 waive 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

**G 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:  .....

**H 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  .....

