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., PO. 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
			| | | | |	☐M ☐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.	☐ Do you use, or have you been using narcotics? ☐ 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.	☐ The nervous system ☐ Cerebrovascular accident (stroke) ☐ Epilepsy ☐ Multiple sclerosis ☐ Muscular dystrophy or other atrophic disease ☐ Reoccurring dizziness ☐ Headaches ☐ Balance disorders ☐ Fainting ☐ Parkinson's syndrome ☐ Alzheimer›s disease ☐ Trembling ☐ Mental retardation ☐ Autism ☐ Down›s syndrome ☐ Cerebral palsy ☐ Poliomyelitis (infantile paralysis) ☐ Gaucher›s disease ☐ Loss of sensation (numbness) ☐ Attention deficit disorders ☐ Migraine ☐ Have you applied to a physician with complaints regarding declined memory (dementia) ☐ AIDS ☐ HIV carrier ☐ 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:** ☐ Cataract ☐ Retina and cornea problems ☐ Glaucoma ☐ Inflammations of the eye ☐ Strabismus ☐ Blindness Other eye disease / problem: ☐ No ☐ Yes, if "Yes" please specify:		
3.	**Heart:** ☐ Cardiac arrhythmias ☐ Heart disease ☐ Heart failure ☐ Heart attack ☐ Congenital heart defect ☐ Catheterization ☐ Heart valve diseases, other heart disease / problem: ☐ No ☐ Yes, if "Yes" please specify:		
4.	**Blood vessels:** ☐ Varicose vein (in the veins of the legs) ☐ Carotid artery (in the arteries of the neck) ☐ Coagulation disorders ☐ Blood disease DVT (Thrombosis) ☐ PVD (Peripheral Vascular Disease), other vascular disease / problem ☐ No ☐ Yes, if "Yes" please specify:		

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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:** ☐ Thyroid gland ☐ Lymph node ☐ Salivary gland ☐ Sweat gland ☐ Pituitary gland ☐ Diabetes ☐ Hypertension ☐ High levels of fats / cholesterol, other metabolic disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
6.	**Respiratory system:** ☐ Asthma ☐ Tuberculosis ☐ COPD (chronic obstructive pulmonary disease) ☐ Hay fever ☐ Recurrent respiratory infections and Shortness of breath ☐ Collapsed lung (Pneumothorax) ☐ Cystic Fibrosis Other respiratory system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
7.	**Digestive system:** ☐ Ulcer (duodenum / gastric) ☐ Heartburn ☐ Crohn's disease ☐ Colitis ☐ Reflux ☐ Hemorrhoids ☐ Fissure / Fistula ☐ Bowel obstruction ☐ Pancreatic diseases / infections ☐ Esophagus ☐ Gallbladder ☐ Gall-bladder stones Other digestive system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
8.	**Liver:** ☐ Jaundice ☐ Hepatitis B, C, D ☐ Fatty liver ☐ Cirrhosis, other digestive system disease / problem ☐ No ☐ 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? ☐ No ☐ Yes, when (date)? .... Is the problem solved? ☐ No ☐ Yes		
10.	**Kidney and urinary tract:** ☐ Recurrent infections ☐ Kidney and urinary stones ☐ Kidney cysts ☐ Anomalies of urinary tract ☐ Renal failure, other kidney and urinary tract disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
11.	**Joints and bones:** ☐ Arthritis ☐ Gout ☐ Back / spine ☐ Joints ☐ Knees Other joints and bones disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
12.	**Skin and sex diseases:** ☐ Skin tumors ☐ Skin lesions ☐ Psoriasis ☐ Sexually transmitted diseases ☐ Syphilis Other skin and sex diseases disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
13.	Malignant tumors / diseases (cancer).		
14.	**For women:** ☐ Breasts (including breast enlargement) ☐ Gynecological system, disease / other feminine problem ☐ No ☐ Yes, if "Yes" please specify: .... ☐ Are you pregnant? ☐ Have you undergone a cesarean delivery? ☐ No ☐ Yes, if "Yes" please specify when (date):		
15.	**For men:** ☐ Prostate problems ☐ Varicocele / Hydrocele Other masculine disease / problem ☐ No ☐ 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:** ☐ Sleep apnea syndrome ☐ Nasal polyp ☐ Sinusitis Other nose, ear and throat disease / problem ☐ No ☐ 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: ....

Date	Name	Passport No.	Signature
....	....	....	....

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