א.רוזן סוכנות לביטוח
להחזיר לפקס 03-6729025

הראל
חברה לביטוח

Policy No.

Health Declaration for Medical Insurance - Foreign Citizens in Israel

Subject to the enclosed Insurance Proposal, which constitutes an integral part of the Health Declaration

Particulars of the applicant

Passport No.	Last Name	First Name	Birth Date	Sex
				M / F

For all the following questions, please circle "Yes" or "No"; if you answer "Yes," please give details as requested.

	General Questions	Yes	No
1.	Are you now sick, or have you been sick at any time during the past five years? Specify illnesses and dates		
2.	Are you now, or have you ever been, under medicinal treatment? Specify medicines		
3.	Have you ever been hospitalized? Specify dates, reasons for hospitalizations and type of treatment administered.		
4.	Do you drink alcoholic beverages?		
5.	Do you now take, or have you ever taken, drugs?		
6.	Have you undergone any laboratory tests and/or medical examinations during the past five years? Specify reason(s), dates, and results, including results that deviate from the norm.		
7.	Have you ever been involved in an accident or undergone a surgical procedure? Specify date(s) and the nature of the surgery and/or accident		
8.	Are you suffering from any chronic disease(s), active or in remission? Specify		
9.	Have you been diagnosed as suffering from autoimmune disease of any type (including lupus)? Specify		
10.	Are you a candidate for any medical treatment, including, among other things, surgery or hospitalization? Specify		
11.	Are you suffering or have you suffered from any infective disease? Specify		
12.	Have you experienced a weight loss of 6 kg or more in the last six months? Specify		
13.	Are you suffering from exhaustion or chronic fatigue? Specify		
14.	Are you aware of any health disorder (including a congenital defect) that is not mentioned in the declaration? Specify		

	Do you have, or have you ever had, the following diseases or conditions	Yes	No
1.	Diseases of the nervous system and the brain, paralyses, epilepsy, motoric disorders? Specify		
2.	Respiratory illnesses, asthma, tuberculosis, chronic pneumonia, hemoptysis? Specify		
3.	Any kind of cardiovascular disease, hypertension? Specify		
4.	Digestive disorders, liver diseases, hepatitis? Specify		
5.	Kidney, urinary tract diseases, dialysis? Specify		
6.	Diseases of the joints and bones; back and neck pain? Specify		
7.	Metabolic disorders, diabetes, thyroid condition, high blood fats, blood disease and clotting, anemia? Specify		
8.	Cancer (malignant disease), chronic degenerative disease? Specify		
9.	Dermatological and sexual diseases, syphlis, H.I.V, wound that doesn't heal, herpes of any type, skin tumors of any type? Specify		
10.	Eye diseases, ear diseases (including hearing defects), throat diseases, diseases of the nose, plastic surgery? Specify		
11.	Have you been found to carry antibodies or be ill with HIV virus or hepatitis?		
12.	**For women only:** a. Are you pregnant?		
	b. Women's diseases: menstrual cycle disorders, breast disease including lumps in the breasts, uterus, ovaries, examinations for detection of a cancerous growth, mammography? Specify		

Please explain all "yes" answers to questions above in detail: _____

I hereby declare that all the details I have provided on this Health Declaration Form are correct and complete. If the details I have provided are found to be incorrect or incomplete, Harel shall consider itself free of commitments and obligations toward me.

Renunciation of Medical Secrecy: I, the undersigned, hereby give my permission to the Kupat Holim Sick Fund and/or its medical institutions, as well as to all the doctors and other medical institutions and hospitals and/or to all the insurance companies and/or to every institution and other body or individual, to provide Harel Insurance Company Ltd (hereinafter "the Requestor") with all the details, without exception, and in the way that shall be demanded by the Requestor, as regards my state of health and/or any disease that I have suffered from in the past and/or that I am currently suffering from and/or that I will suffer from in the future, and I hereby release you from the obligation to safeguard medical secrets and hereby renounce this secrecy toward the Requestor. This Declaration of Renunciation binds me, my estate, and my legal delegates and everyone who will come in my stead. This Declaration of Renunciation shall also apply to the minors.

Declaration of the applicant:

1. I hereby declare, agree and pledge that:
   (1) all the answers I have given above are correct and full, and that I provided them of my own free will.
   (2) the answers specified in the Health Declaration and all other information that shall be given to the insurer, as well as the acceptable terms vis-à-vis the Insurer regarding this matter, shall serve as a fundamental condition for the Insurance Contract between me and the Insurer, and shall constitute an integral part thereof.
   (3) the Insurer reserves the right to decide to accept or reject the Proposal without being obliged to justify its decision. I am full aware that the Insurance Contract shall become valid only after the company submits written confirmation of its acceptance of the candidate for insurance, and after the initial insurance premium has been paid in full.
2. I am aware that: according to this insurance, we will not be provided with health services related to a birth defect or congenital disease (inclusive of hereditary diseases and/or a medical condition and/or a medical disorder and/or an illness, whether currently under treatment or not) and/or its consequences that have worsened, whether directly or indirectly, due to a medical condition that existed prior to the Insurance Inception Date according to the foreign workers ordinance.
3. I hereby declare that no insurance company has rejected my Health Insurance Proposal.

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Polices: SAFE STAY / SAFE STAY +

Declaration of the Policyholder: To the best of my knowledge, that which has been declared by the applicant is correct, and I am not aware of any defect, congenital disease (inclusive of hereditary diseases and/or a medical condition and/or a medical disorder and/or an illness, whether under treatment or not) and/or its consequences, that was caused by and/or has worsened, whether directly or indirectly, due to a medical condition that existed prior to the Insurance Inception Date, and/or any other information that, if it were brought to the Insurer's attention, the Insurer would not enter into a contract to insure the Insured.

Name _____ Date _____ Signature of the Employer _____

*** The Insured signed this Proposal Form after its content had been explained to him in a language he understands.**

Date _____ Signature of the applicant _____ Signature of the employer _____