MENORAMIVTACHIM INSURANCE LTD

מנורהמבטחים ביטוח בע"מ

Insurance proposal for **Meno Medic Top** הצעה לביטוח

1. Particulars of the insurance candidates (all of the required details must be filled out)

1. פרטי המועמדים לביטוח (חובה למלא את כל הפרטים הנדרשים)

שם המעסיק ______________ ת.ז. של המעסיק ______________

כתובת המעסיק: ______________

רחוב מספר עיר מיקוד טלפון

INSURANCE PROPOSAL FORM FOR	❑ A foreign person who has been issued an officially approved Israeli work permit ❑ A tourist ❑ Unauthorized foreign worker in Israel.
TYPE OF PROPOSAL	❑ First policy ❑ Extension of Policy number ______________

I, the undersigned, request that I and members of my family (listed below) will be insured within the Meno - Medic Top Insurrance Policy, for the period **From:** (DD/MM/YY) __ / __ / __ To: (DD/MM/YY) __ / __ /__

Insured's last name	First name	Birth date DD/MM/YY __/__/__	Country of citizenship	Passport number

Insured's Home address ______________

street number state(province) city code country phone

Insured's Address in Israel ______________

number street city code phone

Have you ever been covered by health insurance in Israel? ❑ No ❑ Yes,

Insurance Period ______________

Reasons for not renewing the insurance ______________

Do you smoke? ❑ No ❑ Yes,

Health declaration - (despite the fact that this declaration is written in the masculine gender, it is intended for both sexes)
Please answer all the following questions. For each question place a check mark in the "Yes" or "No" column and, if the finding is positive, write the number of the question and the details in the "Details of positive findings" line.

General questions	לא No	כן Yes
1. Height ________ meters Weight ________ kgs.		
2. Has there been any change in your weight in the past twelve months (not as a result of a diet)?		
3. Do you now, or did you in the past, consume alcohol or drugs?		
4. Do you suffer, or did you suffer in the past, from any disease, injury or damage due to an accident? Did you ever undergo surgery? Do you know of the need for invasive tests, hospitalization or any surgery in the future?		
5. Were you ever hospitalized in a hospital or institution? (Which, when, reason). Attach summaries of illness and updated information.		
6. Are you undergoing any medical treatment or are you under medical supervision?		
7. Do you, or did you, take any medication on a regular or temporary basis?		
8. Have you undergone or have you been recommended to undergo any of the following examinations: catheterisation, cardiac scan, echocardiogram, MRI, CT, endoscopy, examinations to reveal cancerous tumours or other special tests (if yes, please state the type of examination).		
9. Do you, or did you, suffer from any congenital defects, hereditary disease or disability?		
10. Have you felt any deterioration in your health recently?		
11. Are you currently ill with any disease or do you know that you have any health disorder, and did you receive or are you receiving treatment or medications? Please specify, including the dosage and duration of treatment.		
12. Have you ever received a notice from a blood bank following an annual blood donation?		
13. Are you handicapped in the performance of any these activities: rising, lying down, undressing, dressing, washing, shaving, eating and drinking, controlling secretion of bodily fluids, walking, functioning and performing household tasks?		
14. Are you entitled or are you receiving a nursing subsidy from the National Insurance Institute?		
15. Have you suffered or are you suffering from the loss of the ability to work on a part-time or full-time basis?		
16. Family history (parents, children, brothers, sisters, uncles, aunts): Have they ever suffered from heart diseases, diabetes, brain stroke, kidney disease, cancer, other severe diseases?		
17. For women only: Do you suffer or have suffered from female illnesses such as irregular menstruation, fertility problems, bleeding and breast cysts, problems in the uterus and ovaries, irregular findings in a gynecological examination (such as PAP smear) or other gynecological disorders? Are you pregnant? How many fetuses? Have you suffered from any problems in previous pregnancies or in the present pregnancy? Have you given birth by a Caesarean Section?		

02.12 "אפריי

1
2

Questions about diseases Did you ever contract or did you ever suffer from the symptoms of the following diseases	לא No	כן Yes
18. **Heart and Blood Vessels -** A.Heart diseases, chest pains, shortness of breath, rapid heart beats, chest pressure (angina pectoris), myocardial infarction, irregular heart rate, problems with the heart valves, hereditary heart disease,disease of the heart muscle or membrane. B. High blood pressure. C. Blood vessels, leg pain when walking, blood clots, varicose veins, blood cycle disorders, constricted arteries.		
19. **Nervous System -** Dizziness, headaches, fainting spells, paralyses, seizures (epilepsy), T.I.A., loss of memory, loss of sense, degenerative disease, stroke, cerebrovascular accident (C.V.A), tremors, balance disorders, Alzheimer's disease, Parkinson's disease, mental fatigue, senility.		
20. **Mental Disorders -** mental disease, depression, schizophrenia, anxiety, attempted suicide.		
21. **Respiratory Tract -** asthma, chronic bronchitis, emphysema, tuberculosis, blood sputum, recurring infections of the respiratory tract.		
22. **Digestive Tract and Liver -** ulcer (peptic ulcer or duodenum) heartburn, chronic intestinal infections, bleeding in the digestive tract, hemorrhoids, anus problems, chronic liver disease, jaundice, gallstones, pancreas infection, hepatitis (viral or other).		
23. **Kidneys and Urinary Tract -** kidney stones, kidney infections, deformation in the urinary tract, blood or protein in urine, kidney cysts, defective kidney function, infection of the prostate gland (prostatitis).		
24. **Endocrinal and Metabolism Diseases -** diabetes, thyroid gland, kideny ureter, kideny cysts, cerebral ureter and other glands, high levels or fat in the blood (cholesterol, triglycerides).		
25. **Skin and Sex -** syphilis, herpes, skin tumors, moles, blisters and/or sterility problems and/or fertility problems.		
26. **Malignant Diseases (Cancer and AIDS) -** malignant or pre-malignant tumor/s or AIDS, including carriers, specify kind, date and nature of treatment		
27. **Joints and Bones -** joint infection (arthritis), theumatism (galt), back or neck pain, slipped disk, dislocation of shoulder, knee, bones diseases.		
28. **Eyes -** catarat, glaucoma, cross-eyes, blindness, retinal diseases, corneal diseases, vision disorders, diopter number.		
29. **Nose, Ear and Throat -** recurring throat or ear infections, sinusitis, hearing disorders, sleep apnea snyndrome.		
30. Hernias - of the stomach wall, the crotch, surgical scars, in the navel and in the diaphragm.		
31. **Other health disorders and/or other diseases not specified above.**		

Details of positive findings ______________________________

____

____

1. Declaration by the applicants / insurance candidates

I/we, the undersigned, who are insurance candidates, hereby request from the Insurer to insure the insurance candidates in accordance with the content of this form (hereinafter: "the insurance proposal").

I/we hereby declare and agree and undertake that:

a. All the answers specified in the proposal and/or in the health declaration are correct and complete, and I did not conceal from the Insurer anything that is liable to affect the insurer's decision to accept the insurance proposal.
b. The answers specified in the proposal and any other in formation in writing to be given to the Insurer by myself, as well as the Insurer's customary terms in this matter, shall serve as the terms of the insurance contract between myself / between us and the Insurer and shall constitute an inseparable part thereof.
C. I/we hereby confirm and agree that the acceptance or rejection of my/our proposal is at the sole discretion of the Insurer and he is entitled to decide whether to accept or reject the proposal without providing any explanation whatsoever for his decision subject to legal directives.

I/we know that:

1. I/we will not be entitled to health services as specified in the policy if the medical incident, which constitutes an insurance event owing to which I/we will require the health services, stems from a medical condition that predated the date of commencement of the insurance period in accordance with this policy and/or that predated the first date upon which any employer whomsoever, in Israel, arranged medical insurance for me/us (hereinafter: "the first date") and if one of the following applies:
a. I/we confirmed that the insurance event that constitutes the medical problem owing to which I/we require the service stems from a pre-existing medical condition.
b. A physician confirmed, on the basis of the findings presented to him, that the medical problem owing to which I/we require the service stems from a pre-existing medical condition. If I/we spent time outside Israel, after the first date (hereinafter: "the stay") for a period or periods exceeding 90 consecutive days, or exceeding 120 consecutive days if the stay was during my/our period of employment by the same employer — then the first date shall be perceived as the first date after the stay during which I/we was insured in the framework of medical insurance.
2. Notwithstanding the aforesaid in clause 1, above, if three years have passed since the date of 17.10.2001 or since the first date, according to the later of the two, the aforementioned limitations shall not apply with regard to me/us.
3. In addition, the limitations pertaining to the provision of service owing to a pre-existing medical condition shall not apply in an instance in which I/we shall require the health services in accordance with the policy owing to a medical state of emergency. In such a case I/we will be provided with these services for a limited period, during the course of which my/our medical condition will be stabilized in order to permit me/us to be sent outside Israel for further treatment and for a period of 30 days thereafter only.

2. Waiver of medical confidentiality

a. I/we, the undersigned, hereby release any medical institution, any medical laboratory, any medical committee and all the medical and other employees thereof, from the obligation to maintain medical and other confidentiality vis-à-vis Menorah Insurance Company Ltd. (which shall hereinafter be called "Menorah")
b. I/we hereby grant permission to all those listed above — including the medical committees of the National Insurance Institute of Israel, insurers, the Ministry of Health, the District Health Office, the authorities of the IDF, the Ministry of Defense, and any other body or institution whose name is not mentioned in this waiver, and to any insurance company in which I/we was/were insured in the past, or in which I/we are insured at the present time, to provide Menorah or the representatives thereof, together or severally — with all the details, without exception, regarding my/our state of health and regarding any illness from which I/we suffered in the past or that I/we shall suffer in the future, including my/our hospitalization reports and/or my/our medical file and/or list of the physicians that I/we visited and/or the date upon which I/we joined a health fund.
The waiver of medical confidentiality will be utilised insofar as necessary for the clarification of the rights and duties conferred in accordance with this policy and the insurer will not contact the employer to obtain medical information other than in the event of a medical emergency.
c. I/we hereby authorize all the insurance companies and/or the other institutions to transfer to Menorah any information and/or document and/or insurance policy that it shall require.
d. I/we hereby grant permission to Menorah to transfer any medical or personal or other information to the medical service providers that are associated with Menorah for the provision of the medical services in accordance with the policy.
e. I/we hereby declare that I/we shall not have any demand or claim of any kind whatsoever vis-à-vis those mentioned above in connection with the provision of the aforementioned details to Menorah or to the representative thereof — together and severally.
f. This application on my/our part is valid in accordance with the Protection of Privacy Law 5741 — 1981 and it applies to any medical and other information located in the databanks of all the institutions, including the health funds and/or the physicians thereof and/or the employees thereof and/or any person who was authorized by them and/or the service providers specified above.
g. This waiver is binding on me/us, on my/our estate, on my/our representatives according to law and on anyone who may replace them.

This waiver shall apply to my / our minor children whose names are specified, if any such were specified, in the proposal.
I/we confirm that I/we have read and understood the declarations attached to this waiver, all the declarations of my/our minor children are submitted by me/us as the natural guardian/guardians thereof:

First and last name	Passport no.	Signature	Date

02.12 "אפי"

שם: ______ חתימה: ______ תאריך: ______

שם הסוכן: ______ מס' הסוכן ______