

ילדים

MEDICAL DECLARATION
Medical insurance for a child – Medical Insurance policy

The joining and health declaration form

I hereby request to insure my son/daughter in the framework of a Medical Insurance Policy.

Name of the parent holder of the policy: _____
Family name First name Passport No.

Child's name _____ Passport No. _____ Date of birth _____

The declaration of the child's parent

1. I hereby confirm that I have read the explanations to the policy and have understood the nature of the cover.

2. I declare that I know that the claims resulting from a impaired medical condition, a phenomenon or illness which existed prior to this insurance coming into force, will not be covered.

3. I know that medical services for cosmetic surgery, enemy action, alcohol, drugs, attempted suicide, mental disorders, road accidents, Aids, aggravation of an existing medical condition, chronic and malignant illness, periodic medical examinations, pregnancy, venereal diseases, optometry services, alternative medicine, dental treatment apart from first aid, medical treatment outside Israel, work accidents, will not be covered. This clause is together with clause 3 in the Insurance Policy which includes all the other reservations.

We the parents of the above child hereby declare that the above child is healthy and does not have any health problem whatsoever and does not suffer from one of the following illnesses:

Any vascular illness, heart defect, murmur, high blood pressure.

Any kidney diseases

Cancer

Liver, gallbladder, disturbances in digestive system, diabetes.

Invalidity or any defect.

Chronic illness

Nervous disorders, mental illness, epilepsy

Lungs and respiratory system

I Vision or hearing problems

Developmental problems, learning problems

Back and spine problems, joints and bones

Does not receive medical or drug treatment on a permanent basis and is not under medical supervision.

Is not hospitalized in a hospital or any institution

Did not undergo surgery and does not have any need for surgery.

Should the response be positive to one or more of the above items, please provide details

Agreement to exclusion conditions on acceptance

I agree that the request for insurance will be issued:

With a medical supplement payment on condition that it does not exceed 75%.

With an exclusion to the Company's liability according to which it will not be responsible for existing disabilities and/or health limitations of the insurance candidate, their results and consequences.

Signature of the Insured _____

Waiver of medical confidentiality

I hereby waive in my name and the name of my child as its natural guardian, medical confidentiality and empower the Ayalon Insurance Company Ltd. to receive in my name or in my child's name information from any doctor and from any other medical institution on the subject connection with state of health in the past, present and future. I hereby release the doctors and the medical institutions from their obligation to maintain medical confidentiality and I will not have any contention in delivering the information about these matters.

Date

Name of Parent

Signature of Parent