מנורה מבטחים ביטוח בע"מ **א.רוזן סוכנות לביטוח**
להחזיר למייל info@rozen-ins.co.il
פקס, 03-6729025
משרד 03-6735915

סינית

הצעה לביטוח עובדים זרים
2/2019

Meno Medic Top - Proposal for Health Insurance

יש לענות על כל השאלות באופן ברור ומלא. אין להשתמש בקוים או בסימנים במקום מילים.
הטופס מיועד לנשים ולגברים כאחד.

עליך להשיב תשובה מלאה וכנה לשאלות בעניין מהותי. ככל שלא תעשה כן יכול ותהיה לכך השפעה על תשלום תגמולי הביטוח.

All questions must be answered clearly and fully.
Do not use lines or symbols instead of words.
The form is for both men and women.

You must provide full and honest answers to every essential matter you are asked about' and not doing so may have an impact on the payment of insurance benefits

חובה לבחור אחת מבין האפשרויות הבאות please select accordingly :

○ מצטרף חדש / a new candidate
○ חידוש ברצף/ הארכת תקופת ביטוח / renewal/exctension
(במקרה זה אין צורך למלא הצהרת בריאות - in this case there is no need to fulfill a Health declaration)

Name of agent. שם הסוכן: אריק רוזן		Agent no. מספר הסוכן: 548231	
Company/collective Name. שם החברה/קולקטיב	Private company no. מס׳ ח.פ.	agreement no in collective policy / payment per day מספר הסכם בפוליסה / פרמיה ליום	

A. Details of policyholder / present employer — א. פרטי בעל הפוליסה/המעסיק הנוכחי

ID number מס׳ ת.ז.	First Name שם פרטי	Last Name שם משפחה	
Zip code מיקוד	Town עיר	House no מס׳ בית	street רחוב כתובת:
E-mail for receipt of notices, information and mailings דוא"ל לצורך קבלת הודעות, מידע ודיווחים	Cellphone no. מס׳ טלפון נייד	Telephone no. מס׳ טלפון	

B. Insurance Candidate details — ב. פרטי המועמד לביטוח

First name שם פרטי	Last name שם משפחה	Passport no. מס׳ דרכון	
Country of ongin ארץ מוצא	Date of birth תאריך לידה	First date of insurance תאריך ראשון שבוטחת	Gender / מין ○ Male / זכר ○ Female / נקבה
Zip code מיקוד	Town עיר	House no מס׳ בית	*street רחוב כתובת:
E-mail for personal notifications and mailings דוא״ל להודעות אישיות ודיווחים	Cellphone no. מס׳ טלפון נייד	Telephone no. מס׳ טלפון	

* I am aware and I agree that if I do not fill in an *address, the address of the employer will serve the Company for sending notices and/or documents in any matter related to insurance.

* ידוע לי ואני מסכים לכך שככל שלא אמלא כתובת - כתובת המעסיק תשמש את החברה במשלוח הודעות ו/או מסמכים.

C. Insurance period requested — ג. תקופת ביטוח מבוקשת

From מתאריך	To עד לתאריך

* Note: The requested date does not bind the Company; the effective starting date of the insurance is as noted on the Insurance Details Page.

* לתשומת ליבך: תאריך מבוקש זה אינו מחייב את החברה, מועד תחילת הביטוח הקובע הינו כמצוין בדף פרטי הביטוח.

D. Please select The Insurance candidate's occupation — ד. בחר את העיסוק של המועמד לביטוח

○ Nursing care / סיעוד ○ Agriculture / חקלאות ○ Construction / בניין ○ Other industry / אחר

E. Details of previous insurance policies — ה. פרטי ביטוח קודמים

Have you ever been insured by Menora Mivtahim company or any other company? ○ No ○ Yes
If yes, indicate company and the policy number/health care provider membership number:

האם היית מבוטח בחברת מנורה מבטחים או בחברת ביטוח אחרת?
○ לא ○ כן
אם כן, ציין באיזו חברה ומספר הפוליסה/חבר אצל ספק שירותי בריאות:

Insurance period תקופת ביטוח		Company name. שם החברה	Policy no. מס׳ פוליסה	Member ship no. מס׳ חבר
From מתאריך	To עד לתאריך			

F. Payment by credit card — ו. תשלום באמצעות כרטיס אשראי

ניתן לשלם בתשלומים בהתאם לתקופת הביטוח המבוקשת, אם לא צויין מס' תשלומים, ייגבה בתשלום אחד.
You can pay in several installments according to the insurance period

○ 6 חודשים - עד 4 תשלומים. מס׳ תשלומים _____ .Payments No 6 month -up to 4.

○ 12 חודשים - עד 10 תשלומים. מס׳ תשלומים _____ .Payments No 12 month - up to 10.

Insurance applicant personal details — **פרטי המועמד לביטוח**

First Name שם פרטי	Last name שם משפחה	Passport No. מס׳ דרכון

Provision of credit card holder — **פרטי המשלם**

ID number מס׳ ת.ז.	First Name שם פרטי	Last name שם משפחה

Zip code מיקוד	Town עיר	House no מס׳ בית	street רחוב כתובת:

Exp. date בתוקף עד (חודש ושנה)	card no. מספר כרטיס אשראי

Cellphone No . מס׳ טלפון נייד	Email דוא״ל

לידיעתך, אמצעי התשלום ישמש לתשלום דמי הביטוח עבור כל המבוטחים בפוליסה.
ככל שיבוצע החזר של דמי ביטוח, ההחזר יבוצע לאמצעי תשלום זה, אלא אם הוחלט על ידי החברה לבצע את ההחזר לאמצעי תשלום אחר.
היה ופוליסת/ות הביטוח תחודש/נה, יחויב כרטיס האשראי בגין החיובים הנובעים מהפוליסה/ות שתחודש/נה.
הרשאה זו תהיה בתוקף גם לחיוב כרטיס שיונפק ויישא מספר אחר, כחלופה לכרטיס שמספרו מצוין בטופס זה.

For your information, the means of payment will be used to pay the insurance fees for all those insured under the policy.
The amounts and dates of charges will be according to the Company's determination, according to the terms of payment of the insurance policy and the changes made to them from time to time.
This Authorization also be valid for charging a card that will be issued and will carry another number, as an alternative to a card whose number is indicated on this form.

x _____ — **חתימת בעל הכרטיס אשראי / Signature of the credit card holder**

_____ — **תאריך / Date**

Signature of the employer — חתימת המעסיק

The insured signed this Proposal Form after its content had been explained to him in a language he understands.	טופס הצעה זה נחתם בידי המועמד לביטוח לאחר שהוסבר לו תוכנו בשפה המובנת לו.

x _____ — **חותמת וחתימת המעסיק / Stamp & signature of the employer**

_____ — **שם המעסיק / Name of the employer**

_____ — **תאריך / Date**

G. Health declaration

G. 健康声明

for the sake of convenience this declaration is written in the masculine form, but it is intended for both sexes ץ Please answer all the following questions in the "Yes" or "No" column. For each question place a check mark ✓ and if the finding is positive, note the question number and the details in the "Details of positive findings" line.

为行文便利起见，本健康声明以男性的形式表述，但其实是男女通用。请在“是”和“否”的栏位中以打勾的方式（✓）填答以下所有问题。如有任何答“是”的问题，请在下方“详细说明”栏中注明题号并具体说明。

First name 名字	Last name 姓氏	Passport no. 护照号码

	General questions on the medical state	No 否	Yes 是		健康方面一般性问题
1.	Height _____ meters Weight _____ kg			1.	身高 _____ 米，体重 _____ 公斤
2.	Has there been any change in your weight (5 kg and more) in the course of the last twelve months (not as a result of a diet)?			2.	过去 12 个月以来你的体重是否有所变化（5 公斤及以上，且不是因为节食的缘故）？
3.	Do you now, or did you in the past, consume alcohol – more than one glass a day of beer/ wine or another alcoholic beverage?			3.	你现在或以前是否有饮用酒精性饮料的习惯 – 一天一杯以上的啤酒/葡萄酒或其他酒精性饮料？
4.	Do you smoke or have you smoked in the past? ○Today ○In the past, When did you stop? _____			4.	你现在是否吸烟或者过去是否曾吸烟？ ○现在 ○过去，何时戒的烟？ _____
5.	Do you now, or have you in the past, consumed Drugs?			5.	你现在是否吸毒或者过去是否曾吸过毒？
6.	Did you undergo surgery in the course of the last 10 years or was surgery recommended to you?			6.	过去 10 年来你是否动过手术或曾被建议接受手术？
7.	Were you hospitalized in the course of the last 10 years at a hospital or a medical institution? Which one, when, the reason_____ **Enclose medical summary and updated information**			7.	过去 10 年来你是否曾住院或入住医疗机构？哪一家、何时、原因为何？ _____ **请检附病历摘要和最新资料。**
8.	Do you regularly take medication for a chronic condition? **Detail the name of the medication and the reason for taking it**			8.	你是否因为慢性疾病而定期服药？ **请详述药物名称及服用原因。**
9.	**Diagnostic tests:** Have you undergone in the course of the last 10 years or have you been given a recommendation to undergo one or more of the following tests: catheterization, a cardiac scan, echocardiogram, MRI, CT, endoscopy, tests for detection of a cancerous tumor, biopsy and occult blood? **If yes, please state the type of test, time, results of the test and the reason for performing it**			9.	**诊断性检查：** 过去 10 年来你是否做过或曾被建议接受以下一或多项检查？包括：导管插入、心脏扫描、超声心动图、核磁共振（MRI）、电脑断层扫描（CT）、内窥镜、侦测癌症性肿瘤的检查、活体组织切片、潜血检查。 **若有，请说明检查种类、时间、检查结果和进行检查的原因：** _____。

Questions about diseases Were you ever diagnosed with the diseases and/or disorders and/or medical problems listed below?				**疾病方面的问题** 你是否曾被诊断出下列疾病和/或障碍和/或健康方面的问题？	
10.	**Heart and blood** Heart disease, angina pectoris, myocardial infarction, arrhythmias, heart valve problems, congenital heart disease, cardiomyopathy or pericardial disorders. High blood pressure, blood vessel, blood clots, varicose roses, circulation problems, narrowing of the arteries.			10.	**心血管：**心脏病、心绞痛、心肌梗死、心律不整、心脏瓣膜问题、先天性心脏病、心肌病或心包疾病。高血压、血管、血栓、静脉曲张、循环问题、动脉狭窄。
11.	**The nervous system and the brain** Multiple sclerosis, muscular dystrophy, paralysis, spasms (epilepsy), T.I.A, stroke, brain hemorrhage (c.v.a), tremor, ataxia, Parkinson.			11.	**神经系统和脑部：**多发性硬化症、肌营养不良症、麻痹、痉挛（癫痫）、短暂性脑缺血发作（小中风）、中风、脑溢血（脑血管意外）、震颤、共济失调、帕金森氏症。
12.	Diagnosed mental disorders and attempted suicide			12.	被诊断出有精神疾病或曾企图自杀。
13.	**Respiratory system** Asthma, chronic bronchitis, emphysema, tuberculosis, hemoptysis, repeat respiratory tract infections.			13.	**呼吸系统：**气喘、慢性支气管炎、肺气肿、肺结核、咳血、反复呼吸道感染。
14.	**Gastrointestinal tract and liver** Ulcer (gastric or duodenal ulcers), heartburn, chronic inflammatory intestinal infection, gastrointestinal bleeding, hemorrhoids, rectal problems, chronic liver disease, hepatitis, gallstones, pancreatitis, hepatitis (viral or otherwise).			14.	**胃肠道及肝脏：**溃疡（胃溃疡或十二指肠溃疡）、胃灼热、慢性炎症性肠道感染、胃肠道出血、痔疮、直肠问题、慢性肝病、肝炎、胆结石、胰腺炎、肝炎（病毒或其他类型）。
15.	**Kidneys and urinary tract** Kidney stones, kidney infections, urinary tract defects, blood or protein in the urine, renal cysts, renal dysfunction, Prostate.			15.	**肾脏和尿路：**肾结石、肾脏感染、尿路畸形、血尿或蛋白尿、肾囊肿、肾功能异常、前列腺问题。
16.	**Metabolic and endocrine diseases** Diabetes, thyroid disorder, adrenal disorder, kidney cysts, pituitary and other glands, high blood lipids (cholesterol, triglycerides).			16.	**代谢和内分泌疾病：**糖尿病、甲状腺疾病、肾上腺疾病、肾囊肿、脑下垂体和其他腺体问题、高血脂（胆固醇、甘油三酯）。
17.	**Dermatology and Venereology** Syphilis, herpes, skin tumors, moles, warts and/or infertility and/or fertility problems.			17.	**皮肤病和性病：**梅毒、疱疹、皮肤肿瘤、痣、疣和/或不孕和/或生育问题。
18.	Malignant diseases, malignant or precancerous tumor/s, polyps **Detail the type and method of treatment _____Enclose reports and pathology**			18.	恶性疾病、恶性或癌前肿瘤（一或多颗）、息肉。 **请详述种类及治疗方法：** **_____** **请检附报告和病理分析报告。**
19.	Infectious diseases, autoimmune diseases, polio, venereal diseases and AIDS/ HIV. **Enclose medical documents**			19.	传染性疾病、自体免疫疾病、脊髓灰质炎、性病和艾滋病/人类免疫缺陷病毒。 **请检附医学证明文件。**

20.	**Joints and bones** - arthritis, rheumatism (Galt), neck or back pain, herniated disc, dislocation of shoulder, knee, bone disease.			20.	**关节和骨骼：**关节炎、风湿病（肠相关淋巴组织）、颈部疼痛或背痛、椎间盘脱出、肩部脱臼、膝盖、骨骼疾病。
21.	**Eyes -** cataract, glaucoma, strabismus, blindness, retinal disease, cornea disease, visual disturbances, diopter number.			21.	**眼部：**白内障、青光眼、斜视、失明、视网膜疾病、角膜疾病、视觉障碍、屈光度。
22.	**Otolaryngology (nose/ ear/ throat)** - ear recurrent or throat infections, sinusitis, hearing disorders, sleep apnea syndrome.			22.	**耳鼻喉：**反复性耳部和喉部感染、鼻窦炎、听觉障碍、睡眠呼吸中止症。
23.	**Hernia (hernia break)** - of the abdominal wall, groin, surgical scars, navel and solar plexus. **Medical documents must be enclosed**			23.	**疝气：**包括发生于腹腔壁、鼠蹊部、手术切口、肚脐和横膈膜的疝气。 **请检附医学证明文件。**
24.	For women only: Do you suffer or have you suffered from any women's illnesses: irregular menstruation, fertility problems, bleeding and breast cysts, problems in the uterus and ovaries, irregular findings in a gynecological exam (such as PAP)? Are you pregnant? What is the number of fetuses? _____ Have you suffered from any problems in previous pregnancies or in the current pregnancy? Have you given birth by a Caesarean Section?			24.	此题仅由女性回答：你现在是否或者过去是否曾患有妇女疾病？包括：月经不调、生育问题、出血和乳腺囊肿、子宫和卵巢问题、在妇科检查（如宫颈涂片检查）中有异常发现。 你现在是否怀孕？所怀胎儿数_____ 你在先前或在这次的怀孕中，是否曾发生任何问题？ 你是否曾以剖腹方式生产？

Details of positive findings
详细说明

_____

Signature of the Insurance Candidate 被保险人签名	Insurance Candidate name 被保险人姓名	Date 日期

H. Receipt of all the information in the Policy

I hereby permit my insurance agent for the Policy, Mr/Ms _____ , to handle on my behalf and for me all matters related to this claim, including submitting to Menora and receiving from Menora on my behalf and for me all correspondence and/or documents.
related to a claim, and to serve as my representative for all intents and purposes related to this claim.
Signature of the Insured X

H. 收取所有有关本保险单的资讯

本人兹此认可由本人本保险单的保险经纪人，_____先生/女士，代表本人及为本人处理所有有关本理赔事宜，包括代表本人与 Menora 就本理赔事宜进行双向的沟通联系，和/或向 Menora 提交及自 Menora 收取所有文件，并作为本人的代表处理与本理赔事宜相关的各种事务。

被保险人签名 X_____

I. Applicant / insurance candidate declaration

I the undersigned, the insurance candidate, hereby request the insurer to insured the insurance candidate pursuant to the details in this form (hereinafter: "the Proposal").

I hereby represent, agree and undertake that:

1. All of 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 may affect the insurer's decision to accept the insurance proposal.
2. The answers specified in the proposal and any other information in writing to be given to the insurer by me, as well as the insurer's customary terms in this matter, shall serve as the terms of the insurance contract between me and the insurer and shall constitute an integral part thereof.
3. I hereby confirm and agree that the acceptance or rejection of my proposal is at the sole discretion of the insurer and it is entitled to decide whether to accept or reject the proposal subject to the law.
4. I agree that the insurance policy of the insurance plans requested in this proposal be delivered to me by means of the agent whose details appear at the beginning of this proposal.
5. If you wish to receive the policy and/or the information in the framework. of the underwriting procedure and the procedure of joining this policy directly, as well, you may contact menora at any time by phoning menora 03-7107460.

I. 要保人/被保险人声明

本人是下方签署者，即被保险人，兹此请求保险人根据本表（以下简称“投保书”）所载资料为被保险人提供保险。

本人兹此声明、同意并承诺：

1. 投保书和/或健康声明表中所填答内容均正确而完整，而且本人没有对保险人隐瞒任何足以影响保险人是否接受本保险申请决定的事情。
2. 投保书中所填答内容和本人所提供给保险人的任何书面资料，以及保险人针对此类事务所设的一般条款，应作为本人和保险人之间所订立保险合同的条件，并将构成其不可分割的一部分。
3. 本人兹此确认并同意由保险人完全自行决定是否同意或拒绝本人的投保申请，且保险人有权依法决定是否接受或拒绝本人的投保申请。
4. 本人同意本投保书所请求保险方案的保险单将由本人的保险经纪人转交予本人，保险经纪人的联系资讯明载于本投保书开头处。
5. 如果你也想要直接收到有关本保险单和/或有关承保手续和本保险单投保程序的资讯，请随时与 Menora 联系，电话：03-7107460。

J. Waiver of medical confidentiality

I, the undersigned, hereby permit the medical institution and/or your employees and/or any person working on your behalf or as your agent, to provide Menora Mivtachim Insurance Ltd. (hereinafter: the "Requester") with all details, with no exception, regarding my medical condition and/or any disease from which I suffered in the past

J. 医疗保密豁免

本人为下方签署者，兹此允许医疗机构和/或其职员和/或其任何代理，在 Menora Mivtachim Insurance Ltd.（以下简称“请求人”）提出请求下，毫无例外地提供请求人所有有关本人健康情况和/或本人过去所罹患各种疾病和/或本人现在所罹患各种疾病的所有资讯，包括有关本人

and/or from which I suffer at present, including information on psychiatric or other mental therapy that I underwent, in the manner requested by the Requester, and I hereby release you and/or your employees and/or any person working on your behalf or as your agent from the duty of medical confidentiality on all matters related to my medical condition and/or diseases as foregoing, and I waive such confidentiality with respect to the Requester, and shall have no claim or demand against you in connection to the foregoing, including claims by virtue of the Privacy Protection Law and/or the Patient's Rights Law regarding medical confidentiality and/or any other law.	曾接受过的精神治疗或心理治疗的资讯在内。本人兹此免除医疗机构和/或其职员和/或其任何代理针对有关本人健康情况和/或前述疾病事项保守医疗秘密的责任，本人也豁免请求人受此责任的约束，不会就前述事项对其提出任何主张或要求，包括根据隐私权法和/或病人权利法有关医疗保密责任的规定和/或其他法律所提出的主张。
K. Information for the Insurance Candidate	**K. 被保险人须知**
1. According to the terms of the Policy, in the period of 90 days from the date of termination of the insurance period, it is possible to extend the insurance period continuously, subject to payment of insurance fees for the period between the end of the insurance period and extension of the insurance, provided that you continue to work as a foreign worker. After the passage of 90 days from the date of termination of the insurance period, new inclusion in the Policy will involve an underwriting procedure. 2. Insofar as you are a person with disabilities, as defined in the Equal Rights for Persons with Disabilities Law, 5748 - 1998, that is, "a person with a physical, mental or intellectual, including cognitive impairment, whether permanent or temporary, which significantly limits his functioning in one or more of the central spheres of life," please notify us of this through your insurance agent, whose details appear at the beginning of this proposal.	1. 根据本保险单条款规定，只要被保险人继续以外籍劳工的身份工作且缴清自保险期限到期至保险期限展延期间的保费，在保险期限到期后的 90 天内可展延保险期限。若在保险期限到期后 90 天过后，要投保就必须经过承保手续才行。 2. 若被保险人为符合“5748-1998 身心障碍者公平权利法”所定义的身心障碍人士，即“身体、心理、智力，包括认知有所残缺之人，无论此残缺为永久性或暂时性，且此残缺对其打理生活中一或多项核心事务的能力造成显著限制”，请透过保险经纪人告知我司此一事实，保险经纪人的联系方式明载于本投保书开头处。
I confirm that I have read and understood the contents of this proposal, including the representations therein.	**我确认我已阅读过本投保书，包括其中所含声明书，且对其内容充分理解。**
signature for the Insurance Candidate	**被保险人签名**

Signature 签名	Passport no. 护照号码	Insurance Candidate name 被保险人姓名	Date 日期