אנגלית

Tour and Care
Insurance Application for Tourists in Israel

HAREL Insurance & Finance

This Form is designed for men and women alike.
Please make sure that you fill out this Form accurately and completely.

09/2022 Edition

Agent's name: אריק רוזן

Agent's number: 63187

Insurance Period Requested	
From date	To date

I the undersigned (hereinafter, the "Insurance Applicant") ask of "Harel" Insurance Company Ltd. (hereinafter, the "Insurer") to insure me, based on all the content of this Application. The policy documents will be sent to your mobile phone number available to the Harel Company. If you wish to receive these documents by e-mail, you should fill in your e-mail address with the personal details. Alternatively, if you want to receive these document by Israel Post, please note this ..... (the documents will be sent according to the most recent details that appear in our files at the time of sending).

Attn.
Harel Insurance Company Ltd.
Foreign Employees / Tourists Insurance Section
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

A Personal information of insurance applicants (up to the age of 75 years)

	Main Insured	Spouse	Child 1	Child 2	Child 3
Passport number					
Country of passport issuance					
First Name					
Last name					
Date of birth					
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of entry to Israel					
Citizenship					
Purpose of visit					
Address where you are staying in Israel	Street	House No.	Apartment No.	Town	
Mobile phone					
Last name of your host					
E-mail for personal notifications and mailings ..... @					

B Provider selection

☐ Harel's private arrangement ☐ Maccabi Health Services [HMO] ☐ Clalit Health Services [HMO]

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סוג מסמך: 33533

C Health Statement

The Health Statement below shall apply severally to each one of the following: the main Insured, the spouse and each one of the children insured. Please answer the questions below by marking (✔) in the column of the correct answer. If the answer to any of the questions is "Yes", you must attach an up-to-date report from the attending physician regarding the stated problem, test results, the manner of treatment and the current condition.

Is the purpose of the trip for one or more of the travelers is to receive a medical care?	Main Insured		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

If the answer to Question 1 is yes, we cannot accept you in the insurance.

Part A: Have you been diagnosed with an illness, condition, or disorder related to one or more of the issues specified below:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	☐ Stroke ☐ Epilepsy ☐ Multiple sclerosis ☐ Muscular dystrophy or another degenerative disease ☐ Headaches ☐ Migraine ☐ Recurring dizziness ☐ Balance disorders ☐ Fainting ☐ Parkinson's ☐ Alzheimer's* ☐ Mental retardation* ☐ Autism* ☐ Down's syndrome* ☐ Cerebral palsy* ☐ Polio ☐ Gaucher disease* ☐ Loss of sensation ☐ Attention deficit disorder ☐ Have you seen a doctor for complaints related to loss of memory in the last 3 years? ☐ Another problem with the nervous system - Send a detailed medical certificate										
2.	☐ AIDS and/or HIV carrier ☐ Lupus										
3.	Eyes and vision: ☐ Cataract ☐ Retinal problems ☐ Corneal problems ☐ Glaucoma ☐ Eye inflammations ☐ Strabismus ☐ Blindness ☐ Other eye disease/problem										
4.	Heart: ☐ Arrhythmia ☐ Cardiac defects ☐ Heart failure ☐ Heart attack ☐ Congenital heart defect ☐ Catheterization or bypass surgery ☐ Vascular diseases ☐ Other heart disease/problem										
5.	Blood vessels: ☐ Varices in veins of leg ☐ Carotid artery stenosis ☐ Clotting disorders ☐ Anemia ☐ Blood disease ☐ DVT (thrombosis) ☐ PVD (peripheral vascular disease)										
6.	Metabolism: ☐ Thyroid gland ☐ Lymph gland ☐ Salivary gland ☐ Sweat gland ☐ Pituitary gland ☐ Diabetes ☐ Hypertension ☐ High fat/cholesterol ☐ Other metabolic disease/problem										
7.	Respiratory: ☐ Asthma ☐ Tuberculosis in past with full recovery ☐ Active tuberculosis at present ☐ COPD (chronic symptomatic lung disease) ☐ Hay fever ☐ Recurrent infection of respiratory airways and shortness of breath ☐ Pneumothorax ☐ Cystic fibrosis ☐ Other disease/problem of respiratory airways										
8.	Digestive system: ☐ Ulcer (stomach or duodenum) ☐ Heartburn ☐ Crohn's disease ☐ Colitis ☐ Reflux ☐ Hemorrhoids ☐ Fissure/Fistula ☐ Intestinal blockage ☐ Pancreatic diseases/infections ☐ Esophagus ☐ Gall bladder ☐ Gall stones ☐ Other disease/problem of the digestive system?										
9.	Liver: ☐ Hepatitis B, C, D ☐ Hepatitis A ☐ Fatty liver ☐ Cirrhosis ☐ Other liver disease/problem										
10.	Hernia: ☐ In diaphragm ☐ In umbilicus ☐ In right groin ☐ In left groin ☐ At site of surgical scar ☐ In abdominal wall										
11.	Kidneys and urinary tract: ☐ Recurring infections, stones in kidneys or urinary tract ☐ Cysts in kidneys ☐ Defects in urinary tract ☐ Renal failure ☐ Other disease/problem of kidneys and urinary tract										

*The question is addressed only to the parent or guardian of an Insurance Candidate who is a minor or legally incompetent.

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C Health Statement – continue

Part A: Have you been diagnosed with an illness, condition, or disorder related to one or more of the issues specified below:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
12.	Joints and bones: ☐ Arthritis ☐ Gout ☐ Back/spine ☐ Knees ☐ Thighs ☐ Shoulders ☐ Joints ☐ Decline in bone density ☐ Other disease/problem of joints and bones										
13.	Skin and Sex: ☐ Skin tumors ☐ Skin damage ☐ Psoriasis ☐ Sexual diseases ☐ Syphilis ☐ Other skin disease/problem ☐ Other sexual disease										
14.	Malignant tumors*/ Malignant diseases (cancer) - if yes, is the disease or tumor active and/or diagnosed and/or treated in the past two years? ☐ yes ☐ no										
15.	For women: ☐ Benign breast cysts or tumor ☐ Breast augmentation ☐ Fibrocystic breasts ☐ Benign uterine cyst/tumor ☐ Uterine fibroids ☐ Endometriosis ☐ Uterine bleeding ☐ Cervical diseases (CIN) ☐ Benign ovarian cyst/tumor ☐ Polycystic ovaries ☐ Benign cyst/tumor in Fallopian tubes ☐ Recurring miscarriages ☐ Ectopic pregnancy ☐ Have you undergone childbirth by Caesarian section? ☐ Are you pregnant? ☐ Other problem with gynecological system or breasts?										
16.	For men: ☐ Prostate problems ☐ Varicocele ☐ Hydrocele ☐ Other men's disease/problem										
17.	Mental illnesses diagnosed by a psychologist, psychiatrist or family physician: ☐ Depression ☐ Anxiety ☐ Other mental illness										
18.	Ear, nose and throat: ☐ Sleep apnea ☐ Polyp in nose ☐ Sinusitis ☐ Recurring throat infections ☐ Vocal cord nodules ☐ Adenoid ☐ Enlarged nasal concha ☐ Snoring ☐ Deviated septum ☐ Hearing impairment/deafness ☐ Acoustic neuroma (tumor in auditory canal) ☐ Torn eardrum ☐ Tinnitus ☐ Other ear-nose-throat disease/problem										
19.	Have you been diagnosed as suffering allergies?										

Part B: General Questions		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
20.	Do you use or have you used drugs? If yes - ☐ Hashish ☐ marijuana ☐ grass ☐ cannabis Other drug										
21.	Do you or have you regularly drunk alcoholic beverages in a quantity of more than 2 glass a day?										
22.	Have you been referred for and not yet completed a process of investigation of a phenomenon or disease in the past two years **for which no final diagnosis has been determined?** (type of tests: mammogram, bone scan, catheterization, heart scan, echocardiogram, CT, MRI, ultrasound - not as part of prenatal monitoring, biopsy, occult blood, colonoscopy, gastroscopy, colposcopy										
23.	Have you undergone surgery in the past 5 years or has it been recommended that you undergo surgery/ transplant due to a disease/phenomenon/problem that you did not specify in one of the previous questions? Please provide details										
24.	Have you been hospitalized in the past 3 years due to a disease/phenomenon/problem that you did not specify in one of the previous questions? Please provide details										
25.	Have you taken medication or been recommended to take medication in the past 5 years for a disease/ phenomenon/problem that you did not specify in one of the previous questions? Please provide details										

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Please specify (only if you answered "yes" to one of the questions in the Statement): .....

.....

.....

For your information - the policy does not provide coverage for a pre-existing medical condition.

D Confirmation of conditions for acceptance

I agree in advance that insofar as it emerges in the underwriting procedure for me and/or for my child up to the age of 18 that provision of the coverages requested requires the following underwriting conditions, these will be set forth in the Policy issued to me and/or my child up to the age of 18, as relevant

An insurance event related to ..... will not be covered.

Insurance Applicant's Signature				
	Date	Name of Insured	ID No.	Signature
Main Insured				
Spouse				
Child over the age of 18 years				
Child over the age of 18 years				
Child over the age of 18 years				

E Rider for Extra Insurance Fees

Supplemental coverage	Main Insured	Spouse	Child 1	Child 2	Child 3
Medical air transportation					

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F Insurance Applicant's Statement

1. a. The information included in this document is required for your joining the policies and for all other matters and issues pertaining to the policies and the handling thereof. The Company and other companies of the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) and/or anyone on their behalf will make use of it, including the processing, storage and use thereof, for any matter pertaining to the policies and for other legitimate purposes, including by providing the information to third parties acting in the name and on behalf of the Harel Group.

   b. I/we hereby declare that all the answers are correct and complete and are provided out of my/our own free will.

   c. The answers specified in the Health Statement and any other information to be submitted to the Company as well as the Company's customarily prevailing terms and conditions in this matter shall be essential terms, conditions of the insurance contract between you and the Company, and constitute an inseparable part thereof.

   d. The Company may decide to either accept or reject the Application. For your information, the insurance contract shall come into force only after the Company issues a written confirmation of admission of all the insurance applicants.

   e. This consent and statement, including the Health Statement above, shall also apply to the children whose names are listed in the Application and your signature/s on the documents is made also in their names as their guardian.
   Are you authorized to sign these documents on their behalf? ☐ Yes ☐ No.

   f. I hereby confirm that I received essential information regarding the insurance, which included, at the very least, a description of the main elements of the coverage, the insurance premium, the insurance period, the main insurance amounts and the main limitations of liability, and regarding my possibility of obtaining full details about them.

For your information:

2. Preexisting medical condition: an insurance event, substantially caused by the normal course of a preexisting medical condition, which occurred to the Insured during the period in which a restriction applies. A restriction because of a preexisting medical condition, concerning an insured whose age at the beginning of the insurance period is:
   1. Less than 65 years - Shall apply for a period not exceeding one year from the beginning of the insurance period.
   2. 65 years or more - Shall apply for a period not exceeding half a year from the beginning of the insurance period.
3. This medical insurance is subject to a qualification period of 48 hours.
4. I am aware that the insurance contract shall come into force only after the Company issues a written confirmation of admission regarding the Insurance Applicant. In any case, the insurance period shall begin from the date of confirmation by the Insurer, as said above.
5. **Consent to Use of Information**
   I agree, beyond the requirements arising from the law or an agreement, that the information included in this document, as well as additional information about me that is held or will be held by other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) will also serve the companies in the Harel Group and/or parties on their behalf for any purpose related to the other products and services of the companies in the Harel Group (in the area of insurance, long-term savings and finances) and its business partners and in their marketing, including to enable said companies to notify me of information about products and services, and for additional uses that accompany the above-said uses and are necessary to complete them, this also by means of providing the information to third parties that act in the name of and on behalf of the Harel Group.
   ☐ Yes ☐ No
6. **Waiver of medical confidentiality:** I/we the undersigned hereby give permission to an HMO (kupat holim) and/or its medical institutions and/or the IDF, and all the physicians and/or psychiatrists, the other medical institutions and hospitals, the National Security Council (MALAL) and/or the Ministry of Defense and/or any insurance company and/or to any other institution and entity, **insofar as required in order to inquire and settle claims according to the policy and/or for the purpose of the procedure for examining my acceptance to the requested insurance plan** to provide Harel including any information held by the Company and details with no exception and in the form required by those requesting it, about my/our health condition, about any illness I/we had in the past and/or that I/we are ill with now and/or will be ill with in the future and I/we release you from the duty of maintaining medical confidentiality and waiver this confidentiality towards the "requestor." This waiver binds me/us, my/our estate and my/our legal representatives and anyone that appears in my/our place. This waiver will also apply to my/our minor children.
7. By enrolling in this policy, you are authorizing your insurance agent in the policy to submit and to receive on your behalf/and for you all notices and/or documents related to the underwriting and policy enrolment processes.

Insurance Applicant's Signature

	Date	Name of Insured	ID No.	Signature
Main Insured				
Spouse				
Child over the age of 18 years				
Child over the age of 18 years				
Child over the age of 18 years				

Witnessed the signing (the insurance agent)	Date	055027015 ID	אריק רוזן Full name	Signature

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G Agent's Declaration (required clause that the agent must sign)

Agent's Statement of Compliance with Instructions of the Insurance Commissioner's Circular on the Matter of Joining an Insurance Plan:

I confirm that in the process of selling the products specified in this Form of Joining, I complied with all the instructions of the Commissioner of Insurance in the Matter of Joining an Insurance Plan, and specifically, I inquired about the needs of the candidates, I proposed insurance and/or additional coverage, a rider or a service letter to the existing insurance policy that meet/s his/her/their needs and I gave him/her/them all the essential information required.

Date: ..... Name of agent: **אריק רוזן** Signature of agent: .....

H Payment by credit card - according to the arrangement of the Insured/Payer with the credit card company

Personal information of Insurance applicant		
First name	Last name	Passport No.

Personal information of Payer		
ID No.		Cardholder's name
CVV number (3 digits on the back of the card)	Valid until ..... /	Card number

You can pay in several installments depending on the period		
Number of days	1 to 90	91 to 181
Number of payments	1	1 ☐ 2 ☐

Postal code	City	House No. and Street

Email address: ..... @	Telephone

For your information, the means of payment will be used to pay the insurance fees for all those insured under the policy/ies. The amounts and dates of charges will be according to the Company's determination, according to the terms of payment of the insurance policy/ies and the changes made to them from time to time.

Date:	Name of credit card holder:	Credit card holder's signature .....

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Additional information concerning privacy policy of the institutional entities in Harel Group is available on the Group website: www.harel-group.co.il.

>>> טופס זה יש למלא כאשר המשלם איננו המבוטח / בעל הפוליסה <<<

אישור לתשלום דמי ביטוח נסיעות לחו"ל ועובדים זרים על ידי בעל חשבון

הראל
ביטוח ופיננסים

הטופס מיועד לנשים וגברים כאחד.
נא הקפד למלא טופס זה באופן מדויק ושלם.

אני הח"מ ..... מספר זהות ..... טלפון .....

מאשר בזאת לשלם את דמי הביטוח בגין הפוליסות שלהלן:

	שם המבוטח	מספר פוליסה
.1		
.2		
.3		
.4		
.5		

התשלום יבוצע עבור ..... (נא לציין קשרי משפחה, קשר עובד/מעביד, עסק בבעלות המשלם).

אנא מלא את הסעיף הרלוונטי להלן:

א **הוראת תשלום באמצעות שיקים** (מצ"ב פירוט)

	תאריך פירעון	שם הבנק	מספר סניף	מספר השיק	מספר חשבון	סכום בש"ח
				סה"כ		

ב **הוראת תשלום באמצעות העברה בנקאית**

מספר הבנק ..... שם הבנק ..... מספר סניף ..... מספר חשבון .....

ג **הוראת תשלום באמצעות הוראת קבע**

אני הח"מ מאשר לגבות בהוראת הקבע שלי המצ"ב מחשבון ..... בנק .....

סניף ..... עבור הפוליסות המפורטות לעיל.

ד **הוראת תשלום באמצעות כרטיסי אשראי** (מצ"ב פירוט)

☐ ויזה ☐ ישראכרט ☐ דיינרס ☐ אמריקן אקספרס ☐ אחר .....

מספר כרטיס	תוקף	
	שנה	חודש

ידוע לנו כי תשלום דמי הביטוח הנ"ל יבוצע בעבור המבוטח/ים וכי כל החזר של דמי הביטוח, אם יוחזר, יוחזרו באמצעות אמצעי התשלום שבו שולמה הפוליסה, אלא אם מכל סיבה טכנית ו/או שיקול אחר של החברה, יוחלט כי יוחזרו דמי הביטוח לבעל הפוליסה.

יודגש, כי כל תשלום אחר אשר על החברה לשלם מכח הפוליסה/ות או בהקשר אליה/ם יבוצע לפקודת המבוטח בלבד בכפוף להוראות הדין.

ולראיה באנו על החתום:

תאריך ..... שם בעל החשבון ..... מספר זהות ..... חתימת בעל החשבון .....

הצהרת הסוכן/ות

- אני מאשר בחתימתי את נכונות הרשום לעיל.
- אני מתחייב לשמור על הטופס הנ"ל לצרכי בקרה.

תאריך ..... שם סוכן **אריק רוזן** מספר סוכן 63187 חתימת הסוכן .....

סטודיו הראל 3278.4 02/2021