Tour and Care Insurance Policy
Application Form for Scientists and Students in Israel

HAREL Insurance & Finance

This form is designed for men and women alike.
Please fill out this form fully and accurately.

Contact Center:
Harel-Yedidim,Division for Overseas Visitors and Students
Beit M.A.H.,12 Hahilazon st, 8th Floor, Ramat Gan
Tel: +972-3-6386216, Fax: +972-3-6874534, Email: y_health@yedidim.co.il
www.yedidim-health.co.il

Institution: Reichman University

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.

A Personal Details of the Applicant (please print)

Last name	First name	Gender ☐ M ☐ F	Passport number	Date of birth	Citizenship

Home Address

Street	Number	Town/City	Country	Zip Code

E-mail address for the purpose of receiving mailings/information and any other documents relevant to the Harel policy	Phone No.
@	

B Provider

Clalit Health Services

C Health Declaration for Medical Insurance

Please answer the following questions by marking a check (✓) in the column of the correct answer. If you answer "yes" to any of the questions marked with an asterisk (*), please attach an updated certificate from the attending physician regarding the stated problem, examination results, manner of treatment and current condition.
If a positive answer is given to one of the questions on the Health declaration, you may consent to the special terms for acceptance in advance, by signing below. If you do so, insofar as the special terms of acceptance are confirmed by the insurance company, the policy will be issued to you.
You may alternatively opt not to consent to the special terms of conditions for acceptance in advance. In this case, insofar as it is necessary to stipulate special terms for your acceptance, it will be necessary to obtain your consent to these terms, and a policy will not be issued to you and insurance coverage will not be granted until receipt of that consent.

Part 1: General Questions		Yes	No	Details
1.	**A medical examination that has not yet been completed:** during the last 5 years, have you been and/or are you being referred for the following medical and/or diagnostic tests **which are not yet completed and for which there is no final diagnosis:** catheterization, scans, echocardiography, MRI, CT, ultrasound (not as part of routine prenatal care), biopsy, occult blood, colonoscopy or gastroscopy?*	☐	☐	
2.	During the last 5 years, have you undergone surgery or been advised to undergo surgery? **Please provide details.**	☐	☐	
3.	During the last 5 years, have you been hospitalized for more than 3 days? **Please specify the reason for hospitalization and the treatment you received.**	☐	☐	

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

C Health Declaration for Medical Insurance

	Part 2: have you been diagnosed with an illness, symptom, and/or disorder related to one or more of the issues specified below:	Yes	No	
1.	☐ Nervous system* ☐ Epilepsy* ☐ Multiple sclerosis* ☐ Muscular dystrophy or another degenerative disease*	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the problem of the nervous system declared in this question. Signature .....
2.	Eyes and vision: ☐ Impaired vision (lens number above 7 only)) ☐ Retinal detachment ☐ Keratoconus ☐ Blindness	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the eye or vision problem declared in this question. Signature .....
3.	Heart diseases: ☐ Arrhythmia ☐ Cardiac defects ☐ Heart failure* ☐ Cardiomyopathy* Heart valves: ☐ Mitral ☐ Pulmonary ☐ Aortic ☐ Tricuspid	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the heart problem declared in this question. Signature .....
4.	Chronic disease with or without a recommendation to take medication and/or diet treatment during the last 10 years: ☐ Diabetes ☐ Hypertension ☐ Cholesterol ☐ Triglyceride	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the chronic disease declared in this question. Signature .....
5.	The thyroid gland: ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Benign tumor in gland ☐ Malignant (cancerous) tumor in gland*	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the thyroid gland. Signature .....
6.	☐ Asthma ☐ Tuberculosis ☐ COPD (chronic obstructive pulmonary disease)*	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the lung problem declared in this question. Signature .....
7.	Digestive system: ☐ Crohn's disease ☐ Colitis ☐ Gall stones ☐ Liver disease* ☐ Hepatitis B* ☐ Hepatitis C* ☐ Hemorrhoids ☐ Fisura Have you undergone surgery ☐ no ☐ yes On the date ..... was the problem resolved: ☐ no ☐ yes	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the digestive system problem declared in this question. Signature .....
8.	Hernia: Location of hernia: ☐ diaphragm ☐ umbilicus ☐ right groin ☐ left groin	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the hernia declared in this question. Signature .....
9.	☐ AIDS and/or HIV carrier* ☐ Lupus*	☐	☐	
10.	FMF*	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to FMF. Signature .....
11.	Kidney diseases: ☐ Kidney stones (Nephrolithiasis) ☐ Polycystic kidneys* ☐ Renal failure* ☐ Kidney cysts* ☐ Nephrotic syndrome* ☐ Other kidney disease*	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the kidneys. Signature .....
12.	Orthopedic problems: Bulging or herniated disk: ☐ cervical spine ☐ thoracic spine ☐ lumbar spine Joints: ☐ right knee ☐ left knee ☐ right shoulder ☐ left shoulder	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the orthopedic problem declared in this question. Signature .....
13.	Malignant tumors/Malignant diseases (cancer)*	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to cancer of the type Signature .....
14.	For woman: ☐ Benign breast tumors ☐ Benign ovarian tumors ☐ Uterine fibroids ☐ Cervical diseases (CIN)* ☐ Breast augmentation surgery	☐	☐	By signing, I agree in advance that I will not be covered for any insurance event related to the problem declared in this question. Signature .....

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

D 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.

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. **Waiver of medical confidentiality:** I, the undersigned, hereby give permission to the HMO (kupat holim) and/or its medical institutions and/or the all other physicians and psychiatrists, medical institutions and hospitals, and/or any other insurance company and/or any institution and other party, insofar as necessary in order to examine the rights and obligations according to the policy and/or for the purpose of the procedure of examining of my acceptance for the insurance requested, to provide Harel with all the information and details held by the company, without exception, in the form requested by the Requester/s, regarding my health condition, including any disease that I suffered from in the past and/or that I suffer now and/or that I will suffer in the future, and I relieve you from the duty of maintaining medical confidentiality and waive confidentiality in favor of the "Requester". This waiver is binding of my/our estate and my legal representatives and anyone substituting for me.

E Insurance Applicant's Signature

Insurance Applicant
My signature below confirms that I have read and understood this document and accept the terms and conditions set forth in it.

Last Name	First name	Date	Signature

Witness of the signing (the insurance agent)