Application Form - UMS
Tour and Care Insurance Policy

08/2021 Edition

HAREL Insurance & Finance

Please fill out this form fully and accurately.

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).

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	Faculty or Department .....

A Personal Details of the Applicant (please print)

Last name	First name	Gender ☐M ☐F	Passport number		
Country of passport issuance		Date of birth			Citizenship
Address in Israel					
Street	.House No	.Apartment No	Town/City	Zip Code	Phone No.
E-mail address for the purpose of receiving mailings/information and any other documents relevant to the Harel policy			Insurance period: From	To	Total days of insurance

B Provider

Clalit Health Services [HMO]

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

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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.

	Section A: General Questions	Yes	No
1.	☐ Do you use, or have you been using narcotics? ☐ Do you drink, or have you been drinking alcoholic beverages regularly? Please specify the quantity of consumption: ..... glasses per day.		
2.	During the last 5 years, have you been referred to any of the following examinations (other than as part of routine checkups) and not yet taken it, or not yet had a final diagnosis determined for you, such as: chronic illnesses, catheterization, bone mapping, echocardiography, MRI, CT, ultrasound (other than as part of routine prenatal care), biopsy, occult blood, colonoscopy or gastroscopy, autoimmune diseases including lupus (if "Yes", please submit a certificate from the attending physician, stating the reason for performing the examination, the examination outcomes and final diagnosis).		
3.	Are you now, or have you been sometime during the last 5 years, about to undergo a surgery/transplantation? Please describe in details:		
4.	During the last 5 years, have you been hospitalized? Please describe in details the reason for hospitalization and the treatment that you have received.		
5.	During the last 5 years, have you been taking, or have you received a recommendation to take, medications regularly? Please describe in details the problem for which you are treated / have been treated, the treatment, and for how long have you been taking the said medication?		
6.	Have you been diagnosed as suffering from any allergies? Please describe in details:		
	Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:	Yes	No
1.	☐ The nervous system ☐ Cerebrovascular accident (stroke) ☐ Epilepsy ☐ Multiple sclerosis ☐ Muscular dystrophy or other atrophic disease ☐ Reoccurring dizziness ☐ Headaches ☐ Balance disorders ☐ Fainting ☐ Parkinson's syndrome ☐ Alzheimer's disease ☐ Trembling ☐ Mental retardation ☐ Autism ☐ Down's syndrome ☐ Cerebral palsy ☐ Poliomyelitis (infantile paralysis) ☐ Gaucher's disease ☐ Loss of sensation (numbness) ☐ Attention deficit disorders ☐ Migraine ☐ Have you applied to a physician with complaints regarding declined memory (dementia) ☐ AIDS ☐ HIV carrier ☐ Lupus **If the answer to one or more of the questions above is "Yes", please attach an up-to-date letter from the attending neurologist.**		
2.	**Eyes and vision:** ☐ Cataract ☐ Retina and cornea problems ☐ Glaucoma ☐ Inflammations of the eye ☐ Strabismus ☐ Blindness Other eye disease / problem: ☐ No ☐ Yes, if "Yes" please specify:		
3.	**Heart:** ☐ Cardiac arrhythmias ☐ Heart disease ☐ Heart failure ☐ Heart attack ☐ Congenital heart defect ☐ Catheterization ☐ Heart valve diseases, other heart disease / problem: ☐ No ☐ Yes, if "Yes" please specify:		
4.	**Blood vessels:** ☐ Varicose vein (in the veins of the legs) ☐ Carotid artery (in the arteries of the neck) ☐ Coagulation disorders ☐ Blood disease DVT (Thrombosis) ☐ PVD (Peripheral Vascular Disease), other vascular disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
5.	**Metabolic diseases:** ☐ Thyroid gland ☐ Lymph node ☐ Salivary gland ☐ Sweat gland ☐ Pituitary gland ☐ Diabetes ☐ Hypertension ☐ High levels of fats/cholesterol, other metabolic disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
6.	**Respiratory system:** ☐ Asthma ☐ Tuberculosis ☐ COPD (chronic obstructive pulmonary disease) ☐ Hay fever ☐ Recurrent respiratory infections and Shortness of breath ☐ Collapsed lung (Pneumothorax) ☐ Cystic Fibrosis Other respiratory system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		

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C Health Statement – continue

	Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:	Yes	No
7.	**Digestive system:** ☐ Ulcer (duodenum / gastric) ☐ Heartburn ☐ Crohn's disease ☐ Colitis ☐ Reflux ☐ Hemorrhoids ☐ Fissure / Fistula ☐ Bowel obstruction ☐ Pancreatic diseases / infections ☐ Esophagus ☐ Gallbladder ☐ Gall-bladder stones Other digestive system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
8.	**Liver:** ☐ Jaundice ☐ Hepatitis B, C, D ☐ Fatty liver ☐ Cirrhosis, other digestive system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
9.	**Hernia:** Location of the hernia: In the diaphragm / in the navel / in the right groin / in the left groin Have you undergone a surgery to treat the hernia? ☐ No ☐ Yes, when (date)? ..... Is the problem solved? ☐ No ☐ Yes		
10.	**Kidney and urinary tract:** ☐ Recurrent infections ☐ Kidney and urinary stones ☐ Kidney cysts ☐ Anomalies of urinary tract ☐ Renal failure, other kidney and urinary tract disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
11.	**Joints and bones:** ☐ Arthritis ☐ Gout ☐ Back / spine ☐ Joints ☐ Knees Other joints and bones disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
12.	**Skin and sex diseases:** ☐ Skin tumors ☐ Skin lesions ☐ Psoriasis ☐ Sexually transmitted diseases ☐ Syphilis Other skin and sex diseases disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
13.	Malignant tumors / diseases (cancer).		
14.	**For women:** ☐ Breasts (including breast enlargement) ☐ Gynecological system, disease / other feminine problem ☐ No ☐ Yes, if "Yes" please specify: ..... ☐ Have you undergone a cesarean delivery? ☐ No ☐ Yes, if "Yes" please specify when (date):		
15.	**For men:** ☐ Prostate problems ☐ Varicocele / Hydrocele Other masculine disease / problem ☐ No ☐ Yes, if "Yes" please specify:		
16	**Nose, ear and throat diseases:** ☐ Sleep apnea syndrome ☐ Nasal polyp ☐ Sinusitis Other nose, ear and throat disease / problem ☐ No ☐ Yes, if "Yes" please specify:		

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

.....

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D Insurance Applicant's Statement

1. a. The information included in this document is necessary for consideration of your application and for determination and implementation of the terms of your policy. The Company and other companies of the Harel Group (Harel Insurance Investment and Financial Services and its subsidiaries) and/or anyone on their behalf will use it, including processing, storing and use thereof, for any matter pertaining to the policies and for other legitimate purpose, including providing the information to their parties acting on its behalf and on behalf of the Harel Group.
   b. I hereby declare that all the answers are correct and complete and are given out of my own free will.
   c. The answered provided in the Health Declaration and any other information that is submitted to the Company now or in the future, as well as the Company's customary prevailing terms and conditions shall be essential terms and conditions of the insurance contract with 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 the Insurance Applicant.
   e. This Health Declaration and Insurance Applicant's Statement shall also apply to any children for whom policies are issued in which you are named 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.
2. For your information:

   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:
   a. Less than 65 years - Shall apply for a period not exceeding one year from the beginning of the insurance period
   b. 65 years or more - Shall apply for a period not exceeding half a year from the beginning of the insurance period.
3. This health insurance is subject to a qualifying 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. Agreement to Use of Information and Receipt of Advertising Material

   Do you agree, beyond the requirements of the law or agreement, that the information included in this document, as well as additional information about you that is or will be possessed by other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) will be used by the Harel Group and/or anyone on their behalf, including for any matter related to the other products and services of the companies in the Harel Group (in the field of insurance, long-term savings and finances) and in their marketing, including allowing the said companies to inform you of products and services, and also for the purpose of handling other policies and/or insurance products, long-term savings and financing that you hold, processing and storing the information, and also for additional uses associated with the above-said uses and required in order to complete them, and for other related legitimate purposes, including by means of transferring the information to third parties acting on behalf of and in the name 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.

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)

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E 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: ..... Signature of agent: ✎ .....

Please note that we can not accept debit cards for payment, only credit cards are accepted

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

Personal information of Insurance applicant		
Last name	First name	Passport number

Personal information of Payer		
ID/Passport 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 insured period			
Number of days	1 to 120	121 to 180	365 days
Number of payments	1	1☐ 2☐ 3☐ 4☐	Enter number (1 to 10) .....

Postal code (Zip code)	Country and city	House No. and Street

E-mail address:	Mobile phone / 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: ✎ .....

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

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