Health Condition Statement for Medical Insurance – Foreigners in Israel

HAREL Insurance & Finance

Subject to the Health Insurance Proposal included, which is an inseparable part of the Health Condition Statement.

Attn.

Harel Insurance Company Ltd. - Foreign Employees / Tourists Insurance Branch
3 Abba Hillel St., PO. Box 1951, Ramat Gan 5211802, Fax: 03-7348083 email: fax7930@harel-ins.co.il

A Personal information of Insurance Candidate

Passport No.	Last Name	Given Name	Date of birth	Sex
			| | | | | | | |	☐M ☐F

In the Health Condition Statement, answer the following questions by marking "✓" in the column of the correct answer. If you answer "Yes" to any of the questions, please attach an updated certificate from the attending physician addressing the stated problem, examination results, manner of treatment and current condition.

	General Questions	Yes	No
1.	☐ Do you use are have you used drugs? ☐ Do you drink alcoholic beverages regularly (more than 2 glasses a day)?		
2.	During the last 5 years, have you been and/or are you in the process of the following medical and/or diagnostic tests that have not yet been 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? (If so, attach an updated certificate from the attending physician regarding the reason for the tests, the results of the tests, and the final diagnosis)		
3.	Have you undergone surgery or been advised to undergo surgery in the last 5 years? Please provide details.		
4.	Have you been hospitalized in the last 5 years? Please specify the reason for hospitalization and the treatment you received.		
5.	During the past 10 years have you taken or been advised to take medication on a regular basis? Please specify the problem for which you are/were treated, the treatment, and the length of time you have been taking the medication.		
	Have you been diagnosed with an illness, symptom, and/or disorder related to one or more of the issues specified below:		
1.	☐ Nervous system ☐ Cerebrovascular accident ☐ Epilepsy ☐ Multiple sclerosis ☐ Tremors ☐ Muscular dystrophy or other degenerative disease ☐ Parkinson's syndrome If the answer to one or more of these problems is positive, please attach an updated letter from the attending neurologist.		
2.	Eyes and vision (note eyeglasses only if the lens size is higher than 7)		
3.	☐ Heart ☐ Blood vessels		
4.	Thyroid gland		
5.	☐ Asthma ☐ Tuberculosis ☐ COPD (Chronic Obstructive Pulmonary Disease)		
6.	☐ Stomach ☐ Intestines ☐ Esophagus ☐ Gall bladder ☐ Liver ☐ Hepatitis ☐ **Hemorrhoids - have you undergone surgery** ☐ no ☐ yes When? (date) ..... Was the problem resolved? ☐ no ☐ yes		
7.	Hernia: location of hernia: ☐ diaphragm ☐ umbilicus ☐ right groin ☐ left groin. Did you undergo surgery for the hernia? ☐ no ☐ yes When? (date) ..... Was the problem resolved? ☐ no ☐ yes		
8.	AIDS or HIV carrier		
9.	Lupus		
10.	☐ Kidneys ☐ Urinary tract		
11.	☐ Back and spine ☐ Knees ☐ Fractures ☐ Joints		
12.	☐ Skin tumors		
13.	☐ Syphilis		
14.	Malignant tumors / malignant diseases (cancer)		
15.	**For women**: ☐ Breasts ☐ Gynecological system		

Specify: .....

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B Statement of insurance candidate

1. I hereby declare that all the answers are correct, complete and given of my own free will.
2. The answers specified on the Health Statement and any other information to be provided to the insurer as well as the insurer's commonly accepted terms and conditions for this purpose shall serve as essential stipulations of the insurance contract between you and the insurer and shall be inseparable part thereof.
3. The insurer may decide to either except or reject the application without having to justify its standpoint. For your information, the insurance contract enters into force only after the insurer issues a written confirmation on admission of the insured for insurance and after the initial insurance premiums are paid in full. This precondition of full payment of the initial insurance premiums shall not apply if the insurer receives means of payment through which the insurance premium can be collected.
4. The information included in this document is essential for your joining the policy and for all other intents and purposes 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 use the said information, including the processing, storage and use thereof for any purpose pertaining to the policies and other legitimate purposes, even by delivery of the said information to third parties operating on behalf of the Harel Group.
5. Did any insurance company decline or cancel at any time you application for health insurance? ☐No ☐Yes, Specify

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6. **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.

The Insurance Candidate has signed this Health Condition Statement Form after having received an explanation of its content in a language in which he / she is fluent.

Date ..... Signature of Insurance Candidate ✎ ..... Signature of witness ✎ .....

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