Tour and Care
Insurance Application for Tourists in Israel

Please fill out this form fully and accurately.
08/2021 Edition

HAREL Insurance & Finance

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).

Agent's name: .....

Agent's number: .....

Insurance Period Requested	
From date	To date

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

This Form is designed for men and women alike.
Please make sure that you fill out this Form accurately and completely.
05/2020 Edition

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 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.

Section A: General Questions		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	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:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	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:										

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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:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
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:										
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).										

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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:		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
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): .....

.....

.....

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

D Rider for Extra Insurance Fees

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

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E 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	ID	Full name	Signature

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F 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: ✎.....

G 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.