קבוצת איילון
ביטוח • פנסיה • שוקי הון
אנשים לשרות אנשים

איילון
חברה לביטוח בע"מ
אנשים לשרות אנשים

Proposal Form Health Insurance - Foreigners in Israel הצעה לביטוח רפואי - לשוהים זרים בישראל

מס' סוכן	.Agent No	שם הסוכן	Name of the Agent

◯ ביטוח חדש ◯ הארכה/חידוש ◯ החלפה של העובד הנוכחי: מס' דרכון/מבוטח

1. פרטי המועמד לביטוח Insurance applicant personal details

מס' דרכון	Passport No.	שם פרטי	First Name	שם משפחה	Last Name

תאריך לידה	Date of birth	מין	Gender	ארץ מוצא	Country of birth	תאריכי כניסה לישראל	Israel Entry Date
		ז / נ	M / F			ראשון	First
						אחרון	Last

טלפון נייד	Mobile Phone	טלפון בית	Home Phone	כתובת בית	Home Address	כתובת דואר אלקטרוני	e-mail

ביטוחים קודמים בישראל Previous Insurances in Israel כן ◯ yes לא ◯ No	חברת ביטוח Insurance Co	מתאריך From date	עד תאריך To date	חברת ביטוח Insurance Co	מתאריך From date	עד תאריך To date

2. פרטי בעל הפוליסה/המעסיק Details of policy holder

שם Name	ת.ז./ח.פ. ID Number	כתובת Address	כתובת דואר אלקטרוני e-mail

טלפון בית Telephone Number	טלפון נייד Mobile Phone	שם איש קשר	טלפון איש קשר

3. תוכנית ביטוח מבוקשת Insurance program wanted

◯ Care 4 u - לעובדים זרים עפ"י צו עובדים זרים בעלי אישור עבודה בתוקף ◯ Care 4 u - Foreign worker with permit to work in Israel

◯ Medical insurance לתיירים בישראל ◯ Tourist Medical Insurance

תקופת הביטוח המבוקשת: מתאריך _____ עד תאריך _____

Insurance period requested: from _____ to _____

4. דמי הביטוח Insurance premium

פרמיה יומית - $ Daily cost in $	מס' ימי הביטוח No. of days	סה"כ פרמיה ב-$ Total cost in $

5. אופן תשלום Payment method

◯ המחאות - מצ"ב Checks ◯ הוראת קבע - מצ"ב Standing order ◯ הפקדה בנקאית - מצ"ב Bank deposit

◯ כרטיס אשראי Credit Card מסוג: ◯ ויזה ◯ ישראכרט ◯ דיינרס ◯ אחר _____

שם בעל הכרטיס Name of card holder	ת.ז. ID No.	טלפון Telephone No.

מספר כרטיס אשראי Credit card No.	תוקף Exp. date	מס' תשלומים No. of payment

This proposal has been duly signed by the insured after being told of its content in the language he understands.
The appointment of an agent as delegate of the insured. it is hereby declared and agreed upon that insurance agent is the representative of the insurer "Ayalon Insurance Company" Ltd., in everything connected with this insurance proposal, including negatiations towards signing the insurance contract and everything stemming from it.

טופס הצעה זה נחתם בידי המבוטח לאחר שהוסבר לו תוכנו בשפה המובנת לו.
מינוי סוכן כשלוחו של המבוטח:
מוצהר ומוסכם כי סוכן הביטוח הוא נציגו ובא כוחו של המבוטח כלפי איילון חברה לביטוח בע"מ בכל הקשור להצעת ביטוח זו, לרבות משא ומתן לקראת כריתת חוזה הביטוח וכל הנובע מכך.

תאריך Date	שם בעל הפוליסה Name of policy holder	חתימת בעל הפוליסה Signature of policy holder

200604012/8.2012

AYALON INSURANCE COMPANY LTD.

AYALON • INSURANCE • PENSIONS • CAPITAL MARKETS

HEALTH DECLARATION FOR CARE 4 U POLICY / MEDICAL INSURANCE

Details of the applicant for the insurance

Surname	First name	Passport number

Gender M / F	Date of birth	Height	Weight

For the sake of convenience the following questions are worded in the masculine however they apply equally in the feminine. Please mark X in the relevant box. If you answer YES to any question, please provide further details.

	Do you or have you suffered from any of the following illnesses or conditions:	Y	N
1	Nervous system – vertigo, headaches, episodes of fainting, paralysis, epilepsy, memory disorders, loss of sense, degenerative diseases, brain haemorrhage, CVA, loss of balance, Alzheimer's disease, Parkinson's disease, mental infirmity, dementia, multiple sclerosis, mental illnesses.		
2	Respiratory tract – asthma, tuberculosis, pneumonia, bronchitis, emphysema, haemoptysis, recurrent infections in the respiratory tract or chest? If yes, please provide details.		
3	Any heart and blood vessel disease including: heart rhythm disorders, heart valve disorders, heart disease.		
4	High blood pressure: including leg pains when walking, varicose veins, blood circulation problems, constricted arteries. If yes, please provide details.		
5	Digestive system – Peptic illness (peptic ulcers or duodenal ulcers), heartburn, infectious diseases of the intestines, haemorrhages in the digestive system, haemorrhoids, anal problems, liver problems or liver disease, jaundice, gallstones, pancreatic infections? If yes, please provide details.		
6	Hernia including in the groin, diaphragm, abdominal wall or umbilical hernia, surgical scar, femoral rupture, varicocele. If yes, please provide details.		
7	Kidney and urinary tract infections including stones in the kidney, urinary tract, blood / protein / sugar in urine, kidney cyst, prostate problems. If yes, please provide details.		
8	Joints and bone problems including arthritis, gout, back/neck/spine pains, disc/shoulder/knee/ankle/ other joint eruptions (slipped disc), bone diseases. If yes, please provide details.		
9	Problems with metabolism and the immune system including diabetes, problems with the thyroid gland, adrenal gland, pituitary gland or other glands, hyperlipaemia, blood disease or clotting, anaemia? If yes, please provide details.		
10	Malignant diseases (cancer) including malignant or pre-malignant tumours, or pre-malignant illnesses, AIDS / AIDS carrier? (If yes, please state the type, date and manner of treatment).		
11	Skin and sexually transmitted diseases: Herpes, syphilis, skin growths, warts, AIDS, reproductive organ problems. If yes, please provide details.		
12	Eye diseases including cataract, squinting, blindness, cornea or reticulum problems, sight disturbances, astigmatism, glaucoma. Do you wear glasses? If yes please provide details.		
13	Throat infections including recurrent throat or ear infections, rhino-sinusitis, hearing problems, sleep apnoea, snoring? If yes please provide details.		

	General questions	Y	N
1	Are you ill at present or have you suffered from any illness in the last five years, or are you aware of any deterioration in your health or the need for surgery? If yes, please state the illnesses and when.		
2	Do you currently take medication or have you done so in the past? If yes, please state which medicines.		
3	Have you ever been hospitalised? If yes, please state when, the reason and the treatment you received.		
4	Do you drink alcohol? If yes, please state which drinks and the frequency.		
5	Do you smoke? If yes, please state the number of cigarettes per day. Do you take or have you taken drugs?		
6	Have your undergone any laboratory tests such as blood, urine and/or any medical tests including ECG, x-rays (chest, digestive system, kidneys, bones, spine etc.), scans, computerised tomography (CT), MRI. If yes, please state the reason, date and result.		
7	Have you been in an accident or undergone surgery? If yes, please state when and type of surgery or accident.		
8	Do you or have you suffered from total or partial incapacity to work? If yes, please provide details.		
9	Are you disabled? If so at what rate?		
10	Do you use any type of auxiliary medical apparatus?		
11	Have you lost weight in the last six months? If yes, please state.		
12	Do you or have you suffered from any type of infectious disease?		
13	Are you aware of any health defect of any type (including birth defect) which is not mentioned in this form? If yes, please provide details.		
14	Have you been diagnosed as being an autoimmune patient (including lupus)? If yes, please provide details.		
15	Do you suffer from any chronic illness – active or dormant? If yes, please provide details.		
16	Are you waiting to receive any medical treatment including surgery or hospitalisation? If yes, please provide details.		
17	Are you a carrier of the HIV antibody and/or virus or jaundice? If yes, please provide details.		
18	**Gynaecological illnesses, women only:**		
	A Are you pregnant? (If yes, please provide details and the number of foetuses).		
	B Do you or have you suffered from gynaecological illnesses such as: irregular menstruation, fertility problems, bleeding, lumps on breasts, womb, ovaries, abnormal results of gynaecological tests (such as PAP) or other gynaecological problems? If yes, please provide details.		
	C Do you have any breast illness or breast lumps?		
	D Number of previous pregnancies?		
	E Have you suffered from problems in past or current pregnancies? If yes, please provide details.		
	F Have you undergone a Caesarean section?		
	G How many children do you have (including from previous marriages)?		
	H When were you last examined by a gynaecologist?		

Please provide details of any questions to which you have replied Yes:_____

I hereby declare that all of the information I have provided in the health declaration is accurate and complete. If it transpires that the information I have provided is inaccurate or incomplete, Ayalon will be exempt from liability in accordance with the provisions of the Insurance Contract Law.

WAIVER OF MEDICAL CONFIDENTIALITY

I the undersigned, hereby provide my consent to the health fund and/or its medical institutions and/or branches as well as to all doctors, medical institutions and other hospitals and/or to any other insurance companies and/or to any institution and/or any other party to submit to Ayalon Insurance Company Ltd. (hereinafter "the applicant") all details, without exception and in the manner requested, regarding my health condition and/or any illness from which I have suffered in the past and/or which I currently suffer from and/or which I may suffer from in the future and I hereby release them from the duty of maintaining medical confidentiality and exempt the "applicant" from this duty. This waiver of confidentiality binds me, my legal representatives and any party that might replace them.

DECLARATION OF THE APPLICANT FOR THE INSURANCE

1. I hereby declare, agree and undertake as follows: (1) All of the replies are accurate, complete and have been provided willingly. (2) The replies stated in the health declaration and any other information provided to the insurer, together with the insurer's regular conditions in this respect will constitute a fundamental condition to the insurance contract between me and the insurer and will be an integral part of the insurance contract. (3) The insurer is free to decide whether to accept or reject this application without having to justify its decision. I am aware that the insurance contract will take effect solely after the insurer issues a written confirmation of acceptance to the insurance and after the first premium has been paid in full.
2. I am aware that in accordance with this policy the insurer will be exempt from providing any service in connection with any defect, birth defect including any medical condition and/or medical phenomenon and/or illness, whether treated or not and/or its consequences, either direct or indirect, which occurs and/or deteriorates due to a health condition that existed prior to the commencement of the insurance, subject to the provisions of the Foreign Workers Ordinance that relate to the cover under the Care4U policy.

AGREEMENT TO SPECIAL ACCEPTANCE CONDITIONS

I agree to purchase the insurance cover:

- ○ With an additional premium due to medical conditions, on condition that it does not exceed 75%.
- ○ With an exclusion that the insurer will not cover any existing disability and/or health problems of the applicant to the insurance, and their consequences and implications.

DECLARATION OF THE POLICYHOLDER

To the best of my knowledge my declaration is accurate and I am not aware of any defect, birth defect, hereditary illnesses and/or health conditions and/or medical conditions and/or illnesses, whether treated or not and/or their results either direct or indirect which has occurred and/or has deteriorated, due to a health condition that existed prior to the commencement of the insurance and/or any other information which would cause the insurer to refuse to provide the cover under this policy to the insured if this information would have been brought to the attention of the insurer.

This declaration has been signed by the insured after its content has been explained to him/her in a language he/she understands.

Signature of the employer/policyholder	Name of the employer / policyholder	Date of signature	Signature of the employer/ policyholder
Signature of the insured	Name of the applicant for the insurance	Date of signature	Signature of the applicant for the insurance