

Health Condition Statement for Medical Insurance - Foreigners in Israel



Name of Group unit No.

Attn.
Harel Insurance Company Ltd. - Foreign Employees / Tourists Insurance Branch
3 Abba Hillel St., P.O. 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 <input type="checkbox"/> M <input type="checkbox"/> F	email	
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.	During the last six months, have you lost 6kg or more of your weight? If the answer is "Yes", please specify the cause.					
2.	<input type="checkbox"/> Do you use or have you ever used narcotics? <input type="checkbox"/> Do you drink / did you regularly drink alcoholic drinks (more than two glasses a day)?					
3.	Course of examining a symptom or an illness, not yet completed: During the last 5 years, have you been and / or are you now, in course of any of the following medical and / or diagnostic examinations that are not yet completed and there is no final diagnosis yet: catheterization, bone mapping, echocardiography, MRI, CT, ultrasound (not as part of routine prenatal care), biopsy, occult blood, colonoscopy, gastroscopy? (If the answer is "Yes" you should submit a certificate from the attending physician containing a description of the reason for the examination, examination results and final diagnosis).					
4.	During the last 5 years, did you undergo a surgery or have you been advised to undergo a surgery? Please specify.					
5.	During the last 5 years, did you undergo an accident? Please specify what it was, the date of occurrence and what was the nature of injury sustained in the accident.					
6.	During the last 5 years, have you been hospitalized for more than 3 days? Please specify the reason for hospitalization and the treatment given to you.					
7.	During the last 10 years, have you been regularly taking, or have you been advised to regularly take, medications? Please specify what was the problem for which you are treated, what is the treatment and for how long have you been taking the said medication?					
Have you been diagnosed with an illness, symptom, disorder, related to one or more of the issues specified below:						
8.	<input type="checkbox"/> The nervous system <input type="checkbox"/> Cerebrovascular accident <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Functional (limb) weakness <input type="checkbox"/> Tremor <input type="checkbox"/> Muscular dystrophy or other degenerative disease <input type="checkbox"/> Parkinson's syndrome. If the answer is "Yes" for one or more of the issues, you must attach an up-to-date letter from the attending neurologist.					
9.	Mental illness diagnosed by a psychologist, a psychiatrist or a family physician?					
10.	Eye and vision (specify eyeglasses only if lens number is above 7)					
11.	System (otolaryngology): <input type="checkbox"/> Nose <input type="checkbox"/> Ear <input type="checkbox"/> Throat					
12.	<input type="checkbox"/> Heart <input type="checkbox"/> Blood vessels					
13.	<input type="checkbox"/> Blood disorder <input type="checkbox"/> Coagulation disorder					
14.	During the last 10 years, did you have chronic illnesses with recommendation for medication treatment / diet: <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes (including gestational diabetes) <input type="checkbox"/> High level of fats / cholesterol <input type="checkbox"/> Other chronic disease					
15.	The thyroid gland					
16.	<input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Chronic pneumonia <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease) <input type="checkbox"/> Pneumothorax					
17.	<input type="checkbox"/> Stomach <input type="checkbox"/> Intestine <input type="checkbox"/> Esophagus <input type="checkbox"/> Gallbladder <input type="checkbox"/> Liver <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hemorrhoids - did you undergo a surgery: <input type="checkbox"/> No <input type="checkbox"/> Yes, on (date) Has the problem been solved? <input type="checkbox"/> No <input type="checkbox"/> Yes					
18.	<input type="checkbox"/> Hernia: location of hernia - <input type="checkbox"/> In the diaphragm <input type="checkbox"/> In the umbilicus <input type="checkbox"/> In the right groin <input type="checkbox"/> In the left groin <input type="checkbox"/> Did you undergo a surgery to treat the hernia? <input type="checkbox"/> No <input type="checkbox"/> Yes, when? (date) Has the problem been solved? <input type="checkbox"/> No <input type="checkbox"/> Yes					
19.	AIDS and / or HIV carrier					
20.	Lupus					
21.	<input type="checkbox"/> Kidneys <input type="checkbox"/> Urinary tract					
22.	<input type="checkbox"/> Back and spine <input type="checkbox"/> Knees <input type="checkbox"/> Bone fractures <input type="checkbox"/> Joints					
23.	<input type="checkbox"/> Kidneys <input type="checkbox"/> Urinary tract					
24.	<input type="checkbox"/> Skin tumors					
25.	<input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes					
26.	For woman (over the age of 14 years only): <input type="checkbox"/> Breasts including breast augmentation <input type="checkbox"/> Gynecological system <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did you give birth through Cesarean section? If yes, when?					

Specify:

StudioHarel 0980/14094

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 / we, the undersigned, hereby give my / our permission to the HMO ("Kupat Holim") and / or its medical institutions, as well as to all the other physicians and / or psychiatrists, medical institutions and other hospitals, the NII and / or the Ministry of Defense, and / or to any insurance company and / or to any other institution and party, as far as necessary for the purpose of reviewing the rights and obligations under the policy and / or for the process of reviewing my admission to the insurance requested, to provide Harel, including information held by the Company and all the detailed information, without exception, and in the way that would be demanded by the Requester, as regarding my / our health condition and / or any disease that I / we have suffered from in the past and / or that I am / we are currently suffering from and / or that I / we will suffer from in the future, and I / we hereby release you from the obligation to maintain medical confidentiality and hereby waive this confidentiality in favor of the "Requester". This Statement of Waiver binds me / us, my / our estate, and my / our legal delegates and everyone who would replace me / us. This Statement of Waiver shall also apply to my / our minor children.

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 