Health Statement for Medical Insurance - Foreigners in Israel

HAREL Insurance & Finance

Subject to the Insurance Application attached hereto, which is inseparable part of the Health Statement.

This Form is designed for men and women alike.
Please make sure that you fill out this Form accurately and completely.
06/2025 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

(טופס למועמד לביטוח)

A Particulars of the Insurance Applicant

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

In this Health Statement you should answer the following questions by marking "✓" on the column of the appropriate answer. If the answer to any of the questions is "Yes" you have to attach an up-to-date certificate from the attending physician, addressing the stated problem, test results, the manner of treatment and the current status.

Section A: General Questions		Yes	No
1.	Height in cm: ..... Weight in kg:		
2.	☐ 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.		
3.	During the last 10 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).		
4.	Are you now, or have you been sometime during the last 10 years, about to undergo a surgery / transplantation? Please describe in details:		
5.	During the last 10 years, have you been hospitalized? Please describe in details the reason for hospitalization and the treatment that you have received.		
6.	During the last 10 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?		
7.	Have you been diagnosed as suffering from any allergies? Please describe in details:		
Section B: Have you been diagnosed with any illness, syndrome, disorder related to one or more of the issues specified below:			
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:		

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A Particulars of the Insurance Applicant

	Section B: Have you been diagnosed with any illness, syndrome, disorder related to one or more of the issues specified below:	Yes	No
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).		
14.	**For women:** ☐ Breasts (including breast enlargement) ☐ Gynecological system, disease / other feminine problem ☐ No ☐ Yes, if "Yes" please specify: ..... ☐ Are you pregnant? ☐ 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.	**Mental illnesses:** Mental illness that was diagnosed by a psychologist, psychiatrist or family physician.		
17.	**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 provide details: .....

B Details of previous insurance policies

Have you ever been insured by Harel or any other insurance company? ☐ No ☐ Yes
If yes, indicate company and the policy number/health care provider membership number:

Insurance period From / To	Company name	Policy No.	Membership No.

C Power of Attorney of Agent

I hereby authorize my insurance agent for the Policy, Mr./Ms. ....., to handle any matter regarding the Policy, including but not limited to the process of inclusion in the Policy, underwriting procedures, renewal or extension of the Policy for additional periods, submission of claims, changes and other actions in the Policy and so forth, in my name and for me. This includes submitting all correspondence and/or documents related to the above-said matters to "Harel" and receiving them from "Harel. I hereby give you my consent that the insurance agent serve as my delegate in any matter regarding the Policy and my permission to send the insurance agency all the details required by him, in any action related to the Policy, including details of other Policies with which I am insured at Harel, which are not necessarily policies in which the insurance agent to whom I give power of attorney in this agreement of mine is the attending agent.

....
Date Name Signature of the Insured

For your information, copies of the correspondence and/or the documents related to the claim will in any case be sent to the your insurance agent for the policy.

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D Declaration of Insurance Candidate

1. I, the undersigned, hereby request of Harel Insurance Company Ltd. (herein: "the Insurer/Company/Harel") to insure me based on the said in this proposal.

   (a) Privacy

   Harel Insurance Company Ltd. and Harel Pension and Provident Ltd. ("Harel") collect information for the purpose of enrollment in products, providing services, operation and management of product lifecycles, handling of claims, payments and processes, managing and improving the business and services that Harel provides, compliance with the law, customizing and offering products and services based on personal characteristics and for other legitimate purposes. Generally, you are under no legal obligation to provide information, however choosing not to provide information may make it impossible for us to assess a request and provide a service. The information will be transferred to the insurance agent (if there is one) so that the agent can deal with requests and regarding all aspects of the management and operation of products and services, as well as to service providers and other third parties who are authorized to receive the information, in connection with these purposes.
   Additional information about the privacy policy is available on the Harel website, including the methods of communication with the Data Protection Officer in Harel, information about the right of inspection and alteration as well as the right to opt out of direct mailing, can be found via the following link: https://www.harel-group.co.il/t/XSVCTB.

   (b) I hereby declare that all the answers are correct and complete and have been provided of my own free will.

   (c) The answers specified in the Health Declaration and any other information provided to the Company, as well as the customary terms of the Company regarding this matter shall serve as fundamental terms of the insurance contract between you and the Company and shall constitute an integral part thereof.

2. Beneficiaries in case of death
   You may appoint beneficiaries, using the form "Application for update / Change of beneficiaries in case of death". In the absence of beneficiary appointment, the amounts will be paid to the legal heirs under the law, according to inheritance or probate order.

3. **Procedure of Joining:** The company is permitted to decide whether to accept or deny the proposal. For your information, the insurance contract will become effective only after the Company issues written confirmation of acceptance of the candidate for insurance. If further processing requires the clarification of terms, underwriting and acceptance for insurance, the policy shall not be issued for the insurance candidate and shall not become effective until completion of the procedures for the insurance candidate.

4. (a) I authorize my insurance agent for the policy, whose details appear at the beginning of this proposal, to submit to Harel and to receive from Harel in my name and for me all notices and/or documents related to the process of underwriting and the process of joining this policy.

   (b) I agree that the insurance policy of the insurance plans requested in this proposal be delivered to me by means of the agent whose details appear at the beginning of this proposal.

   (c) If you wish to receive the policy and/or the information in the framework of the underwriting procedure and the procedure of joining this policy directly, as well, you may contact Harel at any time, by phoning Harel (*2735).

5. **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.**

6. Sending advertising material	no	yes
(a) Notification regarding receiving advertising material from the Company: The information you provided will be used for sending advertising material by the Company via email, automatic dialing system (autodialer) or text messages (SMS). You may unsubscribe at any time at: https://www.harel-group.co.il/t/QMUYBS; unsubscribe1@harel-ins.co.il; by dialing *2735; or through the QR code below:		

(b) Consent to receive additional advertising material:

☐ In addition to advertisements that the Company may send me based on my aforementioned notice, I also wish to receive advertising material about services and products from all Harel Group companies, their business partners and third parties, by email, autodialer or SMS.
*Harel Group - Harel Insurance Investments & Financial Services Ltd. and its subsidiaries.

Please note - a failure to mark your preference will not be considered a refusal to receive advertising material from the Company (as detailed in Section A above) and it does not invalidate any prior consent. You may change your mind regarding your consent at any time.

7. Has any insurance company ever dismissed or canceled your health insurance application? ☐ No ☐ Yes, if "Yes" please specify: .....

8. **Waiver of medical confidentiality:** I, the undersigned, hereby grant permission to the HMO and / or its medical institutions, as well as to all physicians and / or psychiatrists, the medical institutions and other hospitals, and / or any insurance company and / or any other institution and entity, to the extent necessary to clarify the rights and obligations under the Insurance Policy, and / or for the purposes of reviewal procedure of my admission to the insurance sought, to submit to Harel, including any information held by the company and details without exception and in the form required by the Requesting Party(s), about my health condition, any illness that I have had in the past and / or currently have and / or will have in the future, and I release you from the duty to maintain medical confidentiality and waive this confidentiality in favor of the "Requesting Party". This waiver in writing obligates my legal estate and my legal representatives as well as anyone who will come in my stead.

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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