Application Form - Collective Insurance Policy
Volcani Center

HAREL Insurance & Finance

06/2019 Edition

Please fill out this form fully and accurately.

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).

Contact Center:
Harel-Yedidim, Division for Overseas Visitors and Students
Beit M.A.H., 12 Hahilazon st, 8th Floor, Ramat Gan
Tel: +972-3-6386216
Fax: +972-3-6874534
Email: y_health@yedidim.co.il
www.yedidim-health.co.il

Institution: Volcani Center Faculty or Department .....

A Personal Details of the Applicant (please print)

Last name	First name	Gender ☐M ☐F	Passport number	Date of birth	Citizenship

Address in Israel

Street	Number	Town/City	Zip Code	Phone No.

E-mail address for the purpose of receiving mailings/information and any other documents relevant to the Harel policy @	Insurance period From	To	Total days of insurance

Total premium in US$: ..... Total | Premium in US$ ..... Exchange rate ..... Total amount due NIS .....

B Selection of Provider

Clalit Health Services

C Health Declaration

Please answer the following questions by checking (✔) the correct space. If the answer to any of the questions is "yes", you must attach an up-to-date letter from your physician, stating the problem, tests results, manner of treatment and the current condition.

Part 1: In the course of a medical examination of a symptom or illness not yet completed

		Yes	No	Details
1	During the last two years, have you been referred to the following medical and/or diagnostic tests, that are not yet completed, and no **final diagnosis has been made, as:** catheterization, bone scan, echocardiography, MRI, CT, Ultrasound (except as part of routine prenatal care), biopsy, occult blood, colonoscopy, gastroscopy.			

Part 2: Have you been diagnosed with a disease, syndrome or disorder related to one or more of the following:

		Yes	No	Details
1	**Nervous system (neurology) and brain** ☐ Nervous system ☐ Cerebrovascular Accident ☐ Multiple sclerosis ☐ Muscular dystrophy			
2	**Renal failure**			
3	**Respiratory system** ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Cystic Fibrosis			
4	**Malignant diseases or tumor**			
5	**Immune system** ☐ AIDS and/or HIV carrier ☐ Lupus			

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

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D Riders for Extra Insurance Fees

Supplemental coverage	Yes / No
Worsening of preexisting medical condition	
Pregnancy coverage up to 24 weeks of pregnancy	

E Insurance Applicant's Statement

1.
   a. The information included in this document is necessary for consideration of your application and for determination and implementation of the terms of your policy. The Company and other companies of the Harel Group (Harel Insurance Investment and Financial Services and its subsidiaries) and/or anyone on their behalf will use it, including processing, storing and use thereof, for any matter pertaining to the policies and for other legitimate purpose, including providing the information to their parties acting on its behalf and on behalf of the Harel Group.
   b. I hereby declare that all the answers are correct and complete and are given out of my own free will.
   c. The answered provided in the Health Declaration and any other information that is submitted to the Company now or in the future, as well as the Company's customary prevailing terms and conditions shall be essential terms and conditions of the insurance contract with 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 the Insurance Applicant.
   e. This Health Declaration and Insurance Applicant's Statement shall also apply to any children for whom policies are issued in which you are named 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.
2. For your information:

   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:
   a. Less than 65 years - Shall apply for a period not exceeding one year from the beginning of the insurance period
   b. 65 years or more - Shall apply for a period not exceeding half a year from the beginning of the insurance period.
3. This health insurance is subject to a qualifying 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. Agreement to Use of Information and Receipt of Advertising Material

   Do you agree, beyond the requirements of the law or agreement, that the information included in this document, as well as additional information about you that is or will be possessed by other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) will be used by the Harel Group and/or anyone on their behalf, including for any matter related to the other products and services of the companies in the Harel Group (in the field of insurance, long-term savings and finances) and in their marketing, including allowing the said companies to inform you of products and services, and also for the purpose of handling other policies and/or insurance products, long-term savings and financing that you hold, processing and storing the information, and also for additional uses associated with the above-said uses and required in order to complete them, and for other related legitimate purposes, including by means of transferring the information to third parties acting on behalf of and in the name 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.

Insurance Applicant's Signature

Insurance Applicant - My signature below confirms that I have read and understood this document and accept the terms and conditions set forth in it.

Last Name	First name	Date	Signature

Witness of the signing (the insurance agent)