

Tour and Care
Insurance Application for Tourists in Israel



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

06/2025 Edition

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-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 Web: www.yedidim-health.co.il

A Personal information of insurance applicants (up to the age of 80 years)

Table with 6 columns: Main Insured, Spouse, Child 1, Child 2, Child 3. Rows include: Passport number, Country of passport issuance, First Name, Last name, Date of birth, Gender (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]



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 one of the reasons for you or any of the Insured to come to Israel to receive 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 the above question is yes, we cannot accept you in the insurance.

Part A: Have you been diagnosed with an illness, condition, or disorder related to one or more of the issues specified below:	Main Insured		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

1.	<input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Muscular dystrophy or another degenerative disease <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Recurring dizziness <input type="checkbox"/> Balance disorders <input type="checkbox"/> Fainting <input type="checkbox"/> Parkinson's <input type="checkbox"/> Alzheimer's* <input type="checkbox"/> Mental retardation* <input type="checkbox"/> Autism* <input type="checkbox"/> Down's syndrome* <input type="checkbox"/> Cerebral palsy* <input type="checkbox"/> Polio <input type="checkbox"/> Gaucher disease* <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Attention deficit disorder <input type="checkbox"/> Have you seen a doctor for complaints related to loss of memory in the last 3 years? <input type="checkbox"/> Another problem with the nervous system - Send a detailed medical certificate									
2.	<input type="checkbox"/> AIDS and/or HIV carrier <input type="checkbox"/> Lupus									
3.	Eyes and vision: <input type="checkbox"/> Cataract <input type="checkbox"/> Retinal problems <input type="checkbox"/> Corneal problems <input type="checkbox"/> Glaucoma <input type="checkbox"/> Eye inflammations <input type="checkbox"/> Strabismus <input type="checkbox"/> Blindness <input type="checkbox"/> Other eye disease/problem									
4.	Heart: <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Cardiac defects <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Catheterization or bypass surgery <input type="checkbox"/> Vascular diseases <input type="checkbox"/> Other heart disease/problem									
5.	Blood vessels: <input type="checkbox"/> Varicose veins of leg <input type="checkbox"/> Carotid artery stenosis <input type="checkbox"/> Clotting disorders <input type="checkbox"/> Anemia <input type="checkbox"/> Blood disease <input type="checkbox"/> DVT (thrombosis) <input type="checkbox"/> PVD (peripheral vascular disease)									
6.	Metabolism: <input type="checkbox"/> Thyroid gland <input type="checkbox"/> Lymph gland <input type="checkbox"/> Salivary gland <input type="checkbox"/> Sweat gland <input type="checkbox"/> Pituitary gland <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyper lipidemia <input type="checkbox"/> Other metabolic disease/problem									
7.	Respiratory: <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis in past with full recovery <input type="checkbox"/> Active tuberculosis at present <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) <input type="checkbox"/> Hay fever <input type="checkbox"/> Recurrent infection of respiratory airways and shortness of breath <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Other disease/problem of respiratory airways									
8.	Digestive system: <input type="checkbox"/> Ulcer (stomach or duodenum) <input type="checkbox"/> Heartburn <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Reflux <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Fissure/Fistula <input type="checkbox"/> Intestinal blockage <input type="checkbox"/> Pancreatic diseases/infections <input type="checkbox"/> Esophagus <input type="checkbox"/> Gall bladder <input type="checkbox"/> Gall stones <input type="checkbox"/> Other disease/problem of the digestive system?									
9.	Liver: <input type="checkbox"/> Hepatitis B, C, D <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Fatty liver <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Other liver disease/problem									
10.	Hernia: <input type="checkbox"/> In diaphragm <input type="checkbox"/> In umbilicus <input type="checkbox"/> Right inguinal <input type="checkbox"/> Left inguinal <input type="checkbox"/> At site of surgical scar <input type="checkbox"/> In abdominal wall									
11.	Kidneys and urinary tract: <input type="checkbox"/> Recurring infections, stones in kidneys or urinary tract <input type="checkbox"/> Cysts in kidneys <input type="checkbox"/> Defects in urinary tract <input type="checkbox"/> Renal failure <input type="checkbox"/> Other disease/problem of kidneys and urinary tract									

*The question is addressed only to the parent or guardian of an Insurance Candidate who is a minor or legally incompetent.

Part A: Have you been diagnosed with an illness, condition, or disorder related to one or more of the issues specified below:

		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
12.	Joints and bones: <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back/spine <input type="checkbox"/> Knees <input type="checkbox"/> Hip <input type="checkbox"/> Shoulders <input type="checkbox"/> Joints <input type="checkbox"/> Osteoporosis/ Osteopenia <input type="checkbox"/> Other disease/problem of joints and bones										
13.	Skin and Sex: <input type="checkbox"/> Skin tumors <input type="checkbox"/> Skin nevus <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sexual diseases <input type="checkbox"/> Syphilis <input type="checkbox"/> Other skin disease/problem <input type="checkbox"/> Other sexual disease										
14.	Malignant tumors*/ Malignant diseases (cancer) - if yes, is the disease or tumor active and/or diagnosed and/or treated in the past two years? <input type="checkbox"/> yes <input type="checkbox"/> no										
15.	For women: <input type="checkbox"/> Benign breast cysts or tumor <input type="checkbox"/> Breast augmentation <input type="checkbox"/> Fibrocystic breasts <input type="checkbox"/> Benign uterine cyst/tumor <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Cervical diseases (CIN) <input type="checkbox"/> Benign ovarian cyst/tumor <input type="checkbox"/> Polycystic ovaries <input type="checkbox"/> Benign cyst/tumor in Fallopian tubes <input type="checkbox"/> Recurring miscarriages <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Have you undergone childbirth by Caesarian section? <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Other problem with gynecological system or breasts?										
16.	For men: <input type="checkbox"/> Prostate problems <input type="checkbox"/> Varicocele <input type="checkbox"/> Hydrocele <input type="checkbox"/> Other men's disease/problem										
17.	Diagnosed by a psychologist, psychiatrist or family physician: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other mental illness										
18.	Ear, nose and throat: <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Polyp in nose <input type="checkbox"/> Sinusitis <input type="checkbox"/> Recurring throat infections <input type="checkbox"/> Vocal cord nodules <input type="checkbox"/> Adenoid <input type="checkbox"/> Enlarged nasal concha <input type="checkbox"/> Snoring <input type="checkbox"/> Deviated septum <input type="checkbox"/> Hearing impairment/deafness <input type="checkbox"/> Acoustic neuroma (tumor in auditory canal) <input type="checkbox"/> Torn eardrum <input type="checkbox"/> Tinnitus <input type="checkbox"/> Other ear-nose-throat disease/problem										
19.	Have you been diagnosed as suffering allergies?										

Part B: General Questions

		Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
20.	Do you use or have you used drugs? If yes - <input type="checkbox"/> Hashish / marijuana / grass / cannabis Other drug										
21.	Do you or have you regularly drunk alcoholic beverages in a quantity of more than 2 glass a day?										
22.	Have you not yet completed a medical investigation procedure of a symptom or illness, for which you have been referred, sometime during the past two years, and no final diagnosis has been determined yet? (referral for a test with a specialist doctor and/or for examination such as: mammography, bone scan, catheterization, heart scan, echocardiography, MRI, CT, ultrasound - not as part of prenatal care, biopsy, occult blood, colonoscopy, gastroscopy, EEG, colposcopy and/or an invasive test requiring sedation / anesthesia)?										
23.	Have you undergone surgery in the past 5 years or has it been recommended that you undergo surgery/transplant due to a disease/symptom/ medical problem that you did not specify in one of the previous questions? Please provide details										
24.	Have you been hospitalized in the past 3 years due to a disease/symptom/ medical problem that you did not specify in one of the previous questions? Please provide details										
25.	Have you taken medication or been recommended to take medication in the past 5 years for a disease/ symptom/ medical problem that you did not specify in one of the previous questions? Please provide details										

Details (optional):

.....

.....

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






D

Confirmation of conditions for acceptance - *none mandatory section, can be left empty*

I agree in advance that insofar as it emerges in the underwriting procedure for me and/or for my child up to the age of 18 that provision of the coverages requested requires the following underwriting conditions, these will be set forth in the Policy issued to me and/or my child up to the age of 18, as relevant

An insurance event related to will not be covered.

Insurance Applicant's Signature

	Date	Name of Insured	Passport 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				

E

Rider for Extra Insurance Fees

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

F Insurance Applicant's Statement

1. 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/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. Sending advertising material

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.

6. **Waiver of medical confidentiality:** I/we the undersigned hereby give permission to an HMO (kupa 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 waive 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.

F	Insurance Applicant's Signature	Date	Name of Insured	Passport 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				

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					
Passport / ID No.			Cardholder's name		
CVV number (3 digits on the back of the card)		Valid until /		Card number	
If you use an Israeli credit card, you can pay in several installments depending on the period Days					
Number of days		1 to 90		91 to 181	
Number of payments		1		1 <input type="checkbox"/> 2 <input type="checkbox"/>	
The insurance fees will be paid without linkage to the consumer price index, as long as they are paid in no more than three equal consecutive monthly installments from the beginning date of the insurance Insurance fees that are paid in four or more monthly installments will be subject to linkage to the consumer price index from the beginning date of the insurance period until the actual payment					
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. For your information, if an insurance fee payment is not honored by the credit card company/bank, the collection fees charged the Company for charging you again, insofar as it is charged, will be collected through the existing means of payment for the Policy.					
Date:		Name of credit card holder:		Credit card holder's signature 	

H Agent's Declaration (required clause that the agent must sign) - For office use only
<p>Agent's Statement of Compliance with Instructions of the Insurance Commissioner's Circular on the Matter of Joining an Insurance Plan:</p> <p>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.</p> <p>Date: Name of agent: Signature of agent: </p>

Additional information concerning privacy policy of the institutional entities in Harel Group is available on the Group website: www.harel-group.co.il.

