Application Form - UMS
Tour and Care Insurance Policy

HAREL Insurance & Finance

05/2024 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	Faculty or Department .....

If you are a family member please fill the details below:

I am a: ☐ spouse ☐ child of the student/scientist), which their passport number is: .....

A Personal Details of the Applicant (please print)

Last name	First name		Gender ☐M ☐F	Passport number	
Country of passport issuance			Date of birth		Citizenship
Address in Israel					
Street	.House No	.Apartment No	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

B Provider

(Clalit Health services (HMO)

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

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קוד מסמך - 33533

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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.

		Yes	No
	Is one of the reasons for you or any of the Insured to come to Israel to receive medical care?		
	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:	**Yes**	**No**
1.	☐ Stroke ☐ Epilepsy ☐ Multiple sclerosis ☐ Muscular dystrophy or another degenerative disease ☐ Headaches ☐ Migraine ☐ Recurring dizziness ☐ Balance disorders ☐ Fainting ☐ Parkinson's ☐ Alzheimer's* ☐ Mental retardation* ☐ Autism* ☐ Down's syndrome* ☐ Cerebral palsy* ☐ Polio ☐ Gaucher disease* ☐ Loss of sensation ☐ Attention deficit disorder ☐ Have you seen a doctor for complaints related to loss of memory in the last 3 years? ☐ Another problem with the nervous system - **Send a detailed medical certificate**		
2.	☐ AIDS and/or HIV carrier ☐ Lupus		
3.	Eyes and vision: ☐ Cataract ☐ Retinal problems ☐ Corneal problems ☐ Glaucoma ☐ Eye inflammations ☐ Strabismus ☐ Blindness ☐ Other eye disease/problem		
4.	Heart: ☐ Arrhythmia ☐ Cardiac defects ☐ Heart failure ☐ Heart attack ☐ Congenital heart defect ☐ Catheterization or bypass surgery ☐ Vascular diseases ☐ Other heart disease/problem		
5.	Blood vessels: ☐ Varicose veins of leg ☐ Carotid artery stenosis ☐ Clotting disorders ☐ Anemia ☐ Blood disease ☐ DVT (thrombosis) ☐ PVD (peripheral vascular disease)		
6.	Metabolism: ☐ Thyroid gland ☐ Lymph gland ☐ Salivary gland ☐ Sweat gland ☐ Pituitary gland ☐ Diabetes ☐ Hypertension ☐ Hyper lipidemia ☐ Other metabolic disease/problem		
7.	Respiratory: ☐ Asthma ☐ Tuberculosis in past with full recovery ☐ Active tuberculosis at present ☐ COPD (chronic obstructive pulmonary disease) ☐ Hay fever ☐ Recurrent infection of respiratory airways and shortness of breath ☐ Pneumothorax ☐ Cystic fibrosis ☐ Other disease/problem of respiratory airways		
8.	Digestive system: ☐ Ulcer (stomach or duodenum) ☐ Heartburn ☐ Crohn's disease ☐ Colitis ☐ Reflux ☐ Hemorrhoids ☐ Fissure/Fistula ☐ Intestinal blockage ☐ Pancreatic diseases/infections ☐ Esophagus ☐ Gall bladder ☐ Gall stones ☐ Other disease/problem of the digestive system?		
9.	Liver: ☐ Hepatitis B, C, D ☐ Hepatitis A ☐ Fatty liver ☐ Cirrhosis ☐ Other liver disease/problem		
10.	Hernia: ☐ In diaphragm ☐ In umbilicus ☐ Right inguinal ☐ Left inguinal ☐ At site of surgical scar ☐ In abdominal wall		
11.	Kidneys and urinary tract: ☐ Recurring infections, stones in kidneys or urinary tract ☐ Cysts in kidneys ☐ Defects in urinary tract ☐ Renal failure ☐ Other disease/problem of kidneys and urinary tract		
12.	Joints and bones: ☐ Arthritis ☐ Gout ☐ Back/spine ☐ Knees ☐ Hip ☐ Shoulders ☐ Joints ☐ Osteoporosis/ Osteopenia ☐ Other disease/problem of joints and bones		
13.	Skin and Sex: ☐ Skin tumors ☐ Skin nevus ☐ Psoriasis ☐ Sexual diseases ☐ Syphilis ☐ Other skin disease/problem ☐ 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? ☐ yes ☐ no		
15.	For women: ☐ Benign breast cysts or tumor ☐ Breast augmentation ☐ Fibrocystic breasts ☐ Benign uterine cyst/tumor ☐ Uterine fibroids ☐ Endometriosis ☐ Uterine bleeding ☐ Cervical diseases (CIN) ☐ Benign ovarian cyst/tumor ☐ Polycystic ovaries ☐ Benign cyst/tumor in Fallopian tubes ☐ Recurring miscarriages ☐ Ectopic pregnancy ☐ Have you undergone childbirth by Caesarian section? ☐ Are you pregnant? ☐ Other problem with gynecological system or breasts?		
16.	For men: ☐ Prostate problems ☐ Varicocele ☐ Hydrocele ☐ Other men's disease/problem		
17.	Diagnosed by a psychologist, psychiatrist or family physician: ☐ Depression ☐ Anxiety ☐ Other mental illness		

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

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C Health Statement – continue

	Part A: Have you been diagnosed with an illness, condition, or disorder related to one or more of the issues specified below:	Yes	No
18.	Ear, nose and throat: ☐ Sleep apnea ☐ Polyp in nose ☐ Sinusitis ☐ Recurring throat infections ☐ Vocal cord nodules ☐ Adenoid ☐ Enlarged nasal concha ☐ Snoring ☐ Deviated septum ☐ Hearing impairment/deafness ☐ Acoustic neuroma (tumor in auditory canal) ☐ Torn eardrum ☐ Tinnitus ☐ Other ear-nose-throat disease/problem		
19.	Have you been diagnosed as suffering allergies?		
	Part B: General Questions	**Yes**	**No**
20.	Do you use or have you used drugs? If yes - ☐ 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		

Please specify (only if you answered "yes" to one of the questions in the Statement): .....

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D 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. <u>Notification regarding receiving advertising material from the Company:</u>
   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. <u>Consent to receive additional advertising material:</u>
   ☐ 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 (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.
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.

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D 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

E **Agent's Declaration (required clause that the agent must sign)** ***- For office use only***

Agent's Statement of Compliance with Instructions of the Insurance Commissioner's Circular on the Matter of Joining an Insurance Plan: 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.

Date: ..... Name of agent: ..... Signature of agent: .....

F **Payment by credit card according to the arrangement of the Insured/Payer with the credit card company**

Personal information of Insurance applicant

Last name	First name	Passport number

Personal information of Payer

ID/Passport No.	Cardholder's name

CVV number (3 digits on the back of the card)	Valid until	Card number
	..... /	

Payment in installments is only available with an Israeli credit card — Insurance period: Days

Number of days	1 - 90	91 - 125	126 - 150	151 - 180	181 - 365
Number of payments	1	1 2	1 2 3	1 2 3 4	Other — Enter number (1 to 10)

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 (Zip code) Country and city	House No. and Street

E-mail address:	Mobile phone / 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

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