Application Form - Collective Insurance Policy

The Hebrew University of Jerusalem

HAREL Insurance & Finance

I, the undersigned (hereinafter, "the Insurance Applicant") hereby apply to Harel Insurance company (hereinafter, "the Insurer") to insure me based on the information provided in this Application .

: **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 ..... Student No

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		Total days of insurance
	From	To	

B Provider

Harel's private 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 yet,** such as: catheterizationbone scan, echocardiography, MRI, CT, Ultrasound (except as part of routine prenatal care), biopsy, occult blood, colonoscopy, gastroscopy, blood tests.	☐	☐	

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 a pre-existing medical condition

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D Insurance Applicant's Statement

1. 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.
   a. I hereby declare that all the answers are correct and complete and are given out of my own free will.
   b. 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.
   c. 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.
   d. 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
2. **For your information:** "Pre-existing medical condition" refers to an insurance event substantially caused by the normal course of a pre-existing medical condition that occurs to the Insured during the period of the restriction. The restriction due to a pre-existing medical condition is determined by the age of the Insured at the beginning of the insurance period, as follows:
   a. Under 65 years of age at the beginning of the insurance period - the restriction shall apply for a period not exceeding one year from the beginning of the insurance period.
   b. 65 years of age or older at the beginning of the insurance period - the restriction 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 acceptance of the Insurance Applicant. In any case, the insurance period shall begin upon confirmation by the Insurer, as noted.
5. **Waiver of medical confidentiality:** I, the undersigned, hereby give permission to the HMO and/or its medical institutions and/or the Israel Defense Forces, and to all physicians and/or psychiatrists, medical institutions and other hospitals, to the National Insurance Institute and/or to the Ministry of Defense and/or to any insurance company and/or to any other institution or entity, to the extent necessary in order to clarify the rights and obligations under the policy and/or for the procedure of examining my application for insurance, including any information available to the Company, to deliver to Harel Insurance Company Ltd., hereinafter, the "Requesting Party," all information without exception and in the form required by the Requesting Party/Parties, concerning my health condition, any illness I had in the past and/or which I have now and/or will have in the future, and I hereby release you from the obligation of maintaining medical confidentiality and waive this confidentiality in favor of the Requesting Party. This waiver obligates me, my estate and my legal representatives and anyone who would replace me. This waiver shall also apply to my minor children.

E 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)

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