

# CLAL HEALTH INSURANCE COMPANY LTD.

## CMC

Clal Medi Care

- Please **do not** fill out the parts that are marked with an asterisk (little star).
- Please bring with you the original medical form, filled out, stamped and signed by your family Doctor, upon your arrival to the KPC office in Israel.

### Healthy & Sure

#### Medical Insurance for Foreign Residents in Israel

Tel: 1-800-35-18-35 Fax: 077-6393140

Please fill out this form in a clear and readable script

<b>INSURANCE CANDIDATE and/or POLICY HOLDER in case there is no empoler</b>					
Family Name (Latin letters)		Middle name (Latin letters)		First name (Latin letters)	
Passport no.		Passport expiry date		* Work visa expiry date	
Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Country of origin		Israel entry date (first) * (last)
Blood Type	* Insured's address in Israel		* Cellular telephone		

#### \* THE PROPOSED INSURANCE – To be filled out by the office

Plan		<input type="checkbox"/> Healthy & Sure For tourists in Israel		<input type="checkbox"/> Healthy & Sure For foreign workers according to Foreign Workers Order	
Insurance term		From		To:	
Requested Appendices					
<input checked="" type="checkbox"/> A Death or disability due to accident		<input checked="" type="checkbox"/> B Transfer of body		<input checked="" type="checkbox"/> C Emergency dental care	
<input type="checkbox"/> D _____					

#### \* POLICY

Name of employer		Home address		Home telephone number	
Work address		Workplace telephone	Mobile telephone		Date insured's employment started

**PROPOSAL FORM**

This form is intended for both men and women

## Health state declaration

This health declaration is to be filled out by the candidate and a licensed physician, If there is a Medical history for any of the following, dates should be stated also.

The insurance candidate must respond to all details of the health declaration, and check the answer “yes” or “no” in the body of the questionnaire. If the answer is positive (“yes”), the number of the question is to be written in the space intended for answers of positive findings, and these findings are to be specified, as well as an illness report and the current status.

GENERAL QUESTIONS		No	Yes
1.	Have you ever been hospitalized in a hospital or medical institute? (what kind, when, reason). Attach illness reports and current information.		
2.	Have you ever had an operation or have been advised to have an operation? (Elaborate).		
3.	Have you ever been injured? Do you have any disability? (Elaborate).		
4.	Have you undergone routine tests such as blood, urine or EKG? Were the tests normal? (Elaborate).		
5.	Have you had imaging tests, such as various x-rays (chest, intestines, kidneys, bones, etc.), mapping tests, catheterization, computerized tomography (CT), MRI, US? (State reason, date and results).		
6.	Do you currently have any illness or disease, and are you aware of any health disorder, and have you received and or are receiving treatment or medication? (Elaborate, including dosage and duration of treatment)		
7.	For women only – do you suffer or have you suffered from any women’s diseases, such as menstrual irregularly, fertility problems, hemorrhages, breast masses, uterus or ovary problems, abnormal findings in a gynecological examination (e.g. PAP smear) or other gynecological disorders? If so, elaborate: Are you pregnant? How many fetuses? _____ Have you had problems in previous pregnancies or in the previous pregnancy? If so, elaborate. _____ Have you had a caesarian delivery? _____		
8.	Have you been or are you partially or fully incapacitated and unable to work? (Elaborate).		
9.	Have you ever had a Tetanus Injection? If so please state the date _____		

QUESTIONS ON ILLNESSES (HAVE YOU SUFFERED FROM OR ARE SUFFERING FROM)		No	Yes
10.	Cardiovascular (heart and blood vessels) – A. Heart disease, chest pain, shortness of breath, palpitations, angina pectoris, myocardial infarction (heart attack), arrhythmias, heart valve disorder, congenital heart defect, myocardial or pericardial disease. B. Hypertension. C. Blood vessels – leg pain while walking, blood clots, varicose veins, circulation disorders, arterial stenosis (narrowing).		
11.	Anemia		
12.	Nervous system – dizziness, headaches, loss of consciousness, paralysis, convulsions (epilepsy), TIA, memory disorders, loss of sensation, degenerative disease, stroke, brain hemorrhage (CVA), tremor, balance disorders, Alzheimer’s disease, Parkinson’s disease, mental exhaustion, senile dementia.		
13.	Mental disorders – mental disease, depression, schizophrenia, anxiety, suicide attempt.		
14.	Respiratory tract – asthma, chronic bronchitis, emphysema, tuberculosis, hemoptysis, recurrent respiratory tract infections.		
15.	Rheumatic Fever		
16.	Digestive track and liver – ulcer (gastric or duodenal), heartburn, chronic inflammatory bowel disease, intestinal hemorrhage, hemorrhoids, anal problems, chronic liver disease, jaundice, gallstones, pancreatitis, hepatitis (viral or other)		
17.	Kidneys and urinary tract – kidney stones, nephritis, urinary tract defects, blood or protein in the urine, renal cysts, dysfunction of the kidneys, prostate gland.		
18.	Endocrine (metabolic) disorders – diabetes, disorders of the thyroid gland, suprarenal glands, kidney cysts, pituitary glands and other glands, high blood lipids (cholesterol, triglycerides).		
19.	Skin and genital tract – syphilis, herpes, skin tumors, moles, warts and/or infertility and/or fertility problems.		
21.	Malignant diseases (cancer) and AIDS – malignant or premalignant tumor/s, or aids, including carrier status (specify type, date and management method).		
22.	Joints and bones – arthritis, gout, back or neck pain, ruptured disc, shoulder, knee, bone diseases.		
23.	Eyes – cataract, glaucoma, strabismus (squint), blindness, retina disease, cornea disease, visual disorders, diopter number _____.		
24.	Ear, nose, throat – recurrent throat or ear inflammations, sinusitis, hearing disorders, paroxysmal nocturnal dyspnea (PND)		
25.	Hernia – of the abdominal wall, groin, surgical scar, umbilicus (navel), diaphragm.		
26.	Allergies		
27.	Special Diet		
28.	Other health disorders and/or other diseases not elaborated above.		

**Details of positive findings**

Question no.	Details of findings

**Declaration of the insurance candidate**

I, the undersigned, the insurance candidate, hereby request to be insured according to this proposal (hereinafter: "the Proposal").

1. I am aware that:
  - A. The insurer will not be liable and will not pay any claim stemming directly or indirectly from a preexisting state of defective health, a phenomenon or disease from before the date of insurance commencement, or the date of completion of the insurance proposal, or the health declaration signing date, whichever the later.
  - B. I hereby declare, agree and undertake as follows: All answers specified in the Proposal and/or health declaration are correct and complete, and I have not withheld from the insurer anything that can affect its decision to accept the Proposal for insurance. In the case of omission of information or a false answer, the insurance contract will be void ab initio. The answers stated in the Proposal and any other written information given to the insurer by me and the acceptable terms employed by the insurer on this issue are to serve as terms for the insurance contract between me and the insurer and will constitute an integral part thereof.
  - C. I hereby confirm and agree that the acceptance or rejection of this Proposal is subject to the sole discretion of the insurer (who is entitled to decide to accept or reject the Proposal without providing any explanation to its decision).
2. Declaration of waiver of medical secrecy
  - A. I, the undersigned, hereby release any medical institute, any medical laboratory, and any medical committee and any of their medical and other personnel of the duty of

maintaining medical and other secrecy toward Clal Health Insurance Company Ltd. or Arieih Insurance Company Ltd. (hereinafter: "the Applicant").

- B. I hereby permit the foregoing parties – including the committees of the National Insurance Institute, insurers, the Ministry of Health, the District Health Bureau, the IDF authorities, the Ministry of Defense and any other body or institute whose name is not mentioned herein – and all insurance companies I was previously insured with or am insured with at present, to divulge to the Applicant or its appointees – together and individually – all details, without exception, on my health condition and any illness I have had or have at present, or shall have in the future, my hospitalizations or written medical records or the list of physicians I have visited and/or the date of my joining the healthcare organization.
- C. I authorize all insurance companies and/or other institutes to forward to the Applicant any information and/or document and/or insurance policy demanded thereby.
- D. I hereby declare that I will have no claim or assertion of any kind towards the foregoing parties concerning the divulgence of the aforesaid details to the Applicant or the appointee thereof – together and individually.
- E. This application also applies to the Privacy Protection Law of 5741 – 1981, and applies to all medical or other information stored in the databases of the institutes, including healthcare organizations and/or their physicians and/or their personnel and/or their appointees and/or the aforesaid service providers.
- F. This waiver is binding upon me, my estate and my legal attorneys and any person acting in lieu of me.
- G. This waiver will apply to my minor children whose names have been stated, if stated in the Proposal.

X Date \_\_\_\_\_ Name of candidate \_\_\_\_\_ Passport no. \_\_\_\_\_ Signature \_\_\_\_\_

**Physician's declaration:**

I Have examined Mr/Mrs \_\_\_\_\_ and have to the best of my knowledge detailed all the applicant's medical history above. In my opinion the applicant is capable / Incapable of participating in the program, consisting of hard physical labor and mental stress due to the need to adjusting to a far away, foreign and different place for a period of up to six months.

Date: \_\_\_\_\_ Name of Physician: \_\_\_\_\_ Stamp and Signature of physician: \_\_\_\_\_

**\* Appointment of the agent as the insured's proxy**

According to the Insurance Contract Law of 1981, the agent is considered the insurer's proxy. If you are interested in appointing your insurance agent as your proxy, sign the following wording: Wording of appointment – According to the Insurance Contract Law of 1981, I hereby appoint the insurance agent whose name appears below to be my proxy concerning the negotiations for executing the insurance contract and for the purpose of executing the insurance contract with your company

Date \_\_\_\_\_ Name of insurance candidate \_\_\_\_\_ Signature of policyholder/employer \_\_\_\_\_

**\* Declaration of agent**

I confirm that I have asked the insurance candidate all the questions appearing above and that the answers are as given to me personally by the insurance candidate. I hereby declare that I have informed the insurance candidate of the aforesaid declarations.

Date \_\_\_\_\_ Name of agent \_\_\_\_\_ Agent number \_\_\_\_\_ Signature of agent \_\_\_\_\_

