Application Form

Prestige Shira UMS

For your peace of mind | HAREL Insurance & Finance

3015

Institution ________________________ Faculty or Department ________________________

A. Member's Personal Details (Please print)

Extension of policy number ______________________

Last name	First name	Gender ○ M ○ F	Passport number	Date of birth

	Street	Number	Town	Country	Zip code	Telephone
Address in Israel						
Home address						

E-mail	**Period of Insurance**	From 20	To 20	**Total number of days insured**

Insured days _____________ X Daily premium rate US $ _____________ /day = Total Amount due US $ _____________

Total premium US $ _____________ X Rate of exchange _____________ = Total Amount due NIS _________________

B. Declaration of Health

Please answer the following yes/no questions by checking the appropriate box and provide any relevant details in the section below.

Questions	No	Yes
1. Have you been hospitalized at any time? If so, when and for what reason?		
2. Have you suffered at any time from heart disease, cancer,cerebral disorder, nervous disorders or any other health condition?		
3. Have you at any time required an operation?		
4. Have you at any time suffered an injury as a result of an accident?		
5. Have you at any time suffered from any form of disability?		
6. Have you suffered from any illnesses or are you aware of any health condition?		
7. Are you on medication for any medical disorder?		

Details about the existing conditions. If you responded "yes" to any of the above questions, please note the question number, followed by details (including the date) of the condition. **In addition, please attach a letter from your physician stating the current status of the condition.**

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Comments: ______________________________________

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I have been presernted with the choice of three policies and their respective benefits, limitations and exclusions.

Date ______________ Signature ______________

C. Personal Declaration

I declare and confirm that I have read the Terms & Conditions of the policy and its exclusions.

○ I hereby declare that I am not suffering from any illness or accident. I am not handicapped. I am not undergoing any medical treatment of any kind. I do not, nor have I in the past suffered from any chronic medical condition (such as heart disease, high blood pressure, disability, etc. or a congenital disability, or a malignant disease). I am not aware of any need for medical treatment, hospitalization or surgery.

○ I am aware that the benefits under this policy do not cover treatment arising from any existing diseases, injuries, ailments or conditions (as indicated in the "yes" column) for which I have been diagnosed or which have required medical treatment, including prescription drugs.

Renunciation of Medical Confidentiality: I, the undersigned, hereby give my permission to the health service provider and/or its medical institutions, as well as to all the doctors and other medical institutions and hospitals and/or to all the insurance companies and/or to any institute, other body and/or individual to provide Harel Insurance Company Ltd. (hereinafter "**the Requestor**") with all the details, without exception, and in the manner required by the Requestor regarding my state of health and/or any disease that I have suffered from in the past and/or that I am currently suffering from and/or that I will suffer from in the future, and I hereby release you from any obligation to safeguard medical confidentiality and renounce this confidentiality toward the Requestor. This Declaration of Renunciation binds me, my estate and my legal delegates and anyone who will come in my stead. This Declaration of Renunciation shall also apply to minors.

D. Details of Health Insurance in Home Country – please check and/or complete the appropriate statement.

○ Insurance company ________________________________
policy number ____________________

○ I have health insurance in my home country, but do not remember the details.

○ I have no health insurance in my home country.

E. I hereby certify that all the information I have provided on this form is accurate and true.

F. I am aware that the validity and scope of this insurance policy are determined by the health declaration that I have completed and signed, as well as by other factors.

By signing this document, I am hereby responsible to inform the Harel Insurance Co. immediately of any change in my medical condition that occurs during the period between the date of my signature on the health declaration and the beginning of the insurance policy.

Furthermore, without derogating from any legal right held by the Harel Insurance Co. in accordance with the terms of the policy, I am aware that this policy will in no event cover any new medical condition that occurs during the period between the date of my signature on the health declaration and the beginning of the insurance policy.

Date ________________ Signature ______________________________

Contact Center: Harel-Yedidim, Division for Overseas Visitors and Students

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