A.ROZEN INSURANCE AGENCY
FAX : 03-6729025
א.רוזן סוכנות לביטוח

Policy No.

HEALTH DECLARATION FOR MEDICAL INSURANCE POLICY

Details of insured _____ _____ _____
Passport No. Family Name First Name

_____ _____ _____ _____
High Weight Date of birth Gender F / M

	General questions	N	Y
1	Are you presently ill or did you suffer from any illness in the last five years, or do you know of any health problem or the need for surgery? Detail which illness and when		
2.	Are you presently or in the past did you receive any medicinal treatment? Detail which drugs.		
3.	Were you hospitalized at any time in a hospital or an institution? Give details when and the reason for your hospitalization and the treatment you received?		
4.	Do you drink alcoholic drinks?		
5	Do you smoke? / state the number of cigarettes a day. Do you drink alcohol of any type? State what you drink and the quantity. Do you or did you use drugs?.		
6.	Did you undergo any laboratory tests and/or medical tests whatsoever in the last 5 years? Detail the reason, date and any abnormal results.		
7.	Have you had an accident or surgery? Give details when and the nature of the surgery or accident.		
8.	Did you not work for period exceeding 3 days over the last two years?		
9.	Have you been given any invalidity rating?		

		N	Y
	Do you or did you suffer from illnesses or any phenomenon or did any of your relations of the first degree suffer from these illnesses?		
1	Illnesses of the nervous system and brain: Paralysis, multiple sclerosis, fainting, arthritis, gout, epileptic firs, Alzheimer's, Parkinson's, motoric disturbances? Give details		
2	Illness of the respiratory system, asthma, tuberculosis, chronic pneumonia? Give details.		
3	Heart and blood illnesses of any type, high blood pressure? Give details		
4	Illnesses of the digestive system, diseases of the liver , jaundice? Give details		
5	Illnesses of the kidneys and the urinary system? Give details		
6	Illnesses of joints and bones, fractures, back and neck aches? Give details		
7.	Metabolic illnesses and the immune system, diabetes, thyroid glands, high level of fats in the blood, blood and clotting illnesses, osteoporosis, jaundice, anemia? Give details		
8	Cancer (malignant illness), chronic degenerative disease? Give details		

		N	Y
10	Are you assisted by any medical instrumentation?		

		N	Y
9	Skin and sexual diseases: syphilis, Aids, a wound that does not heal.		
10	Eye diseases, ear diseases including hearing disfunction, throat diseases? Give details.		
11	For women only a. Are you pregnant? b. Female illnesses: Menstruation disturbances, illnesses of the breasts including lumps in the breast, the uterus, the ovary, examination to discover a cancerous growth, mammography? Give details. c. Number of children (including from previous marriages) d. Number of pregnancies. Please state whether there were problems during pregnancy. e. When did you have your last gynecological examination?		

הרואה 18 רמת-גן 52432 טל: 03 - 6735915 פקס: 03 - 6729025
18 HA-ROEH ST. RAMAT-GAN 52432 Tel: 03-6735915 Fax: 03-6729025

Details of positive findings in the health questions:

_____

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I hereby declare that all the details that I gave in the health declaration are correct and full. If any of the details I gave are not correct or complete, Ayalon will be exempt from it liability under the Insurance Contracts Law.

WAIVER OF MEDICAL CONFIDENTIALITY

I the undersigned hereby authorize the Sick Funds and/or their Medical Institutions and/or all doctors, medical Institutions and other hospitals, and/or to all insurance companies, and/or to every institution and/or every other factor to give to the insurance company hereinafter – **"the Applicant"** all the details without exception and in a form that will be required by the applicant of the state of my health and/or every illness that I suffered in the past and/or am suffering at present and will suffer in the future, and I hereby release you from your obligation of medical confidentiality and waive this confidentiality to the applicant. This letter of waiver obligates me, my estate and my legal attorneys and everyone who replaces me.

Name of insured_____ Passport No._____

Signature of insured_____ Date:_____

Name of witness to signature_____ Id. No._____

Signature of witness_____ Date_____

INSURED'S DECLARATION

1. I hereby declare, agree and undertake that:
   (1) All the answers are correct, complete and given of my own free will.
   (2) The responses detailed in the health declaration and all other information given to the insurer and all the conditions acceptable with the insurer for this purpose, will be a fundamental condition of the insurance contract between me and the insurer and will be an integral part of the insurance contract..
   (3) The insurer has the authority to decided to accept the proposal or reject it without being required to justify its decision. I know that the insurance contract comes into force only after the insurer issues a written certificate of accepting me for the insurance and after the first insurance fees have been fully paid.
2. I know that:
   According to this policy the insurance company will be exempt from providing service regarding a defect, illness from birth, including my health condition and/or a medical phenomenon and/or medical illness, whether it is being treated, and/or not, or their results, whether directly or indirectly caused and/or became more serious due to my state of health that existed prior to the date of start of the insurance and all this subject to the aforesaid in the Foreign Workers Order.
3. I hereby declare that no insurance company rejected my health insurance proposal.

DECLARATION OF POLICY HOLDER

As far as I know, the declaration by the insured is correct and I do not know of any defect, illness from birth including genetic illness and/or state of health and/or medical phenomenon and/or illness, whether treated or not, and/or the results, whether directly or indirectly, which were caused and/or became more serious due to the state of health thatexisted prior to the date of the start of the insurance and/or all other information which, had been brought to the knowledge of the insurer, the insurer would not have engaged in this policy and insure the insured.

Agreement to exclusion conditions on acceptance

I agree that the request for insurance will be issued:

☐ With a medical supplement payment on condition that it does not exceed 75%.

☐ With an exclusion to the Company's liability according to which it will not be responsible for existing disabilities and/or health limitations of the insurance candidate, their results and consequences.

Signature of the Insured_____

- **This declaration was signed by the insured after the contents had been explained to him/her in a language he/she understands.**

Signature of the insured

Name of the insured_____ Signature of the Insured _____ Date of signature_____