אנגלית

א.רוזן סוכנות לביטוח
03-6729025 להחזיר לפקס

Phoenix Kav Ha'briut
The phoenix Insurance Company LTD
Head Office 53 Derech Hashalom, Givatayim 53454, Israel
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Info Center
*3455
03-7332222

Phoenix

Insurance Proposal and Health Declaration

77619	ארייק רוזן	פרטי הסוכן
מספר סוכן	שם סוכן	

Details of the policy owner

Full name	I.D. No.	Address

Details of the insured

First name	Surname	Passport number	Birth date	Sex
				○ male ○ female

Nationality	Insurance starting date	Last day of insurance	Occupation in Israel	Date of first arrival in Israel

Have you been out of the country for a period of over 90 consecutive days? ○ Yes ○ No Why?

Have you been insured in Israel in the past? ○ Yes ○ No By which company? When did the previous insurance end?

Helth Declaration (If any answer is "yes", please give details)

1		Do you consider yourself healthy and have you been totally fit for work during the last 12 months?	○ Yes	○ No
2		Have you ever been hospitalized or been in a medical institution? Did you undergo any surgery?	○ Yes	○ No
3		Have you been examined by any physician during the last two years? Do you have to see a physician now?	○ Yes	○ No
4		Are you under medical supervision? Do you routinely take medication?	○ Yes	○ No
5		Has surgery been recommended to you? Do you need surgery?	○ Yes	○ No
6		Have you ever been injured? Do you have any disability? If Yes – what percentage due to which reasons?	○ Yes	○ No
7		Have you submitted a request for/are you receiving compensation payments for disability?	○ Yes	○ No
8		Have you been subjected to a medical test including: E.K.G., X-rays, imaging tests, echo, angioplasty, computerized tomography - CT, blood tests, blood counts, urine test, occult blood?	○ Yes	○ No
9		Do you smoke? If Yes – how many cigarettes a day?	○ Yes	○ No
10		Are you addicted to narcotics, or have you been in the past? If Yes – specify. Are you addicted to alcoholic beverages, or have you been in the past? If Yes – ___ per week?	○ Yes	○ No
11		Are you suffering from or have you suffered from:	○ Yes	○ No
	a	A congenital defect? An inherited disease or disability? Nervous system and brain, including: head aches, dizziness?	○ Yes	○ No
	b	Respiratory tract diseases including: ongoing coughing, recurring inflammations, asthma,	○ Yes	○ No
	c	Diseases of the heart, blood veins;blood diseases, high blood pressure, blood circulation disorders, chest pains.	○ Yes	○ No
	d	Diseases of the digestive tract, liver, gall bladder, pancreas, including: abdominal pains, digestive disturbances.	○ Yes	○ No
	e	Diseases of the kidneys or urinary tracts, prostate gland. Dermal and sexually transmitted diseases, Aids.	○ Yes	○ No
	f	Metabolic diseases, nodal diseases, including: enlarged nodes, high blood fat levels, rheumatic fever (gout), chronic fever diseases, blood and clotting diseases, anemia, allergies, thyroid diseases.	○ Yes	○ No
	g	Diseases of the joints and bones, skeletal system and muscles, including: back and neck pains.	○ Yes	○ No
	h	Severe diseases, including: cancer (malignant disease), diabetes, mental disorders, heart attack, kidneys, liver, immune deficiencies, clotting deficiencies, other severe diseases	○ Yes	○ No
	i	Eye diseases, vision disturbances. Diseases of the ear and throat, nose, sinuses, hearing impairments.	○ Yes	○ No
	j	Chronic pains at locations, which have not been mentioned.	○ Yes	○ No
	k	Hernia – in the abdominal groins.	○ Yes	○ No
12		Women's diseases, including: Disturbances in menstrual cycle, bleedings, uterus, ovaries, breast diseases, including lumps in the breasts, cancer detection tests, such as: mammography, pap smear (cervix). Have you given birth through caesarian section? Are you pregnant?	○ Yes	○ No
13		Height ____ and weight ____ Has any change in your weight of over 12 Kg. taken place over the last 5 months?	○ Yes	○ No

Date	Name of the insured	Witness to the signature	Signature

If any answer is Yes, please explain in English

	Explanation to question No.	Explanation to question No.
1. Name of disease or description.	1.	1.
2. Tests and treatments you were subjected to in connection with the illness.	2.	2.
3. If you are taking medication, specify type and quantity.	3.	3.
4. Have you been hospitalized and for how long? In Israel or abroad?	4.	4.
5. Illnes starting date.	5.	5.
6. Have you recovered?	6.	6.

***** If there is insufficient space, please explain on the other side of the page and sign at the end of the addition (in Hebrew or English).**

Waiver of medical confidentiality

I, the undersigned, hereby authorize the health fund and/or its medical institutions, as well as all other medical institutions and hospitals and/or all insurance companies and/or any institution and/or any other party to forward to the Phoenix Insurance Company Ltd., henceforth the "Petitioner", without any exemption, and in a way as will be requested by said "Petitioner", all particulars regarding the condition of my health and/or illness I have experienced in the past and/or of which I am currently suffering, or of which I may suffer in the future, and I relieve you from the obligation of protecting medical confidentiality, and relinquish this confidentiality vis-à-vis the "Petitioner". This declaration of waiver is binding upon me, upon my heirs, and upon my legal representatives and anybody who may replace me.

I authorize by my signature medical add-ons or deviations as a result of medical problems or illnesses or injuries present before I commenced the above-noted insurance. In addition, I authorize by my signature medical add-ons of up to 50% and/or medical deviations as a result of a pre-existing condition.

Date	Name of the insured	Witness to the signature	Signature