איילון
חברה לביטוח בע"מ
אנשים לשירות אנשים

הצעה לביטוח רפואי - לשוהים זרים בישראל
Proposal Form Health Insurance - Foreigners in Israel

הטופס מנוסח בלשון זכר ומיועד לנשים ולגברים

No Agent / מספר סוכן	Name of Agent / שם סוכן
322460	אריק רוזן

א.רוזן סוכנות לביטוח
משרד 03-6735915

למשלוח הטופס חזרה למשרדנו - בדוא"ל info@rozen-ins.co.il **או בפקס: 03-6729025 משרד : 03-6735915**

Status of insurance / סטטוס ביטוח

New insurance / ביטוח חדש ☐ הארכה / חידוש

The purpose for coming to Israel / נא סמן את סיבת הגעתך לישראל:

Nursing care / סיעוד ☐ Agriculture / חקלאות ☐ Construction / בניין ☐ Industry / תעשייה ☐ Other / אחר ________________

1. תוכנית ביטוח מבוקשת / Insurance program wanted (נא לסמן X בריבוע המתאים. / Please mark X at the correct square)

פוליסה לעובדים זרים עפ"י צו עובדים זרים בעלי אישור עבודה בתוקף / Policy for Foreign worker with permit to work in Israel
Medical insurance לתיירים בישראל / Tourist Medical Insurance
תקופת הביטוח המבוקשת / Insurance period requested: מתאריך / from date ________________ עד תאריך / Up to Date ________________

2. פרטי המועמד לביטוח / Insurance applicant personal details

Passport No / מספר דרכון	Last Name / שם משפחה	First Name / שם פרטי	Date of birth / תאריך לידה	Gender / מין
				ז / M ☐ נ / F

Country of birth / ארץ לידה	Israel entery day / תאריכי כניסה לישראל	e-mail / כתובת דואר אלקטרוני

Mobile phone / טלפון נייד	Another phone No / טלפון נוסף	Address / כתובת בית בישראל		
		רחוב, מס' בית / street,house no.	עיר / Town	מיקוד / Zip code

Previous Insurances in Israel / ביטוחים קודמים בישראל	
כן / Yes לא / No	חברת ביטוח / Insurance Co ________________ מס' חבר קופ"ח / Membership No ________________ מתאריך / From date ________________ עד תאריך / Up to date ________________ >>>

3. פרטי בעל הפוליסה/המעסיק / Details of policy holder

ID No / מספר זהות	Last Name / שם משפחה	First Name / שם פרטי	שם איש קשר	טלפון של איש קשר

Mobile phone / טלפון נייד	Another phone No / טלפון נוסף	e-mail / כתובת דואר אלקטרוני

Address / כתובת בית		
רחוב, מס' בית / street,house no.	עיר / Town	מיקוד / Zip code

4. דמי הביטוח / Insurane premium

Daily cost in NIS / פרמיה יומית בש"ח	No. of days / מס' ימי ביטוח	Total cost in NIS / סה"כ פרמיה בש"ח

5. אופן התשלום / Payment method

המחאה ☐ הוראת קבע ☐ הפקדה בנקאית		
כרטיס אשראי / Credit Card מסוג: ☐ ישראכרט ☐ ויזה ☐ דיינרס ☐ אחר ________________		
Name of card holder / שם בעל הכרטיס	ID No / מס' זהות	Telephone No. / מס' טלפון
Credit card No. / מספר כרטיס אשראי	Exp. date / תוקף	No. of payments / מס' תשלומים

Date / תאריך	Name of policy holder / שם בעל הפוליסה	Signature of policy holder / חתימה

HEAD OFFICE: AYALON HOUSE, 12 Abba Hillel Silver St., Ramat Gan 52008
mail@ayalon-ins.co.il www.ayalon-ins.co.il P.O.B. 10957 ISRAEL

DECLARATION OF HEALTH
MEDICAL INSURANCE FOR FOREIGN WORKERS OR TOURISTS

1. Details of the proposer						
Surname	First name	Passport number	Gender	Date of birth	Weight	Height
			M / F			

For the sake of convenience the form is worded in the masculine however applies equally in the feminine [*note to translator – only translate this if applicable in the target language*]. Please reply to the questions in English or Hebrew.

2. Declaration of health
Please mark X in the relevant box. If you answer YES to any question, please provide further details. You may be required to provide additional medical documents from your doctor concerning any medical condition, test result and details of any treatment you receive.

General questions		**YES**	**NO**
1.	In the last ten years have you had any surgery or been advised to undergo surgery?		
2.	In the last ten years have you been hospitalised? If yes, please state when and the reason and attach a medical report from the hospital and a report concerning your current condition.		
3.	Do you currently take medication on a regular basis or have you done so in the last ten years? If yes, please state the name of the medicine and the reason why you take it.		
4.	Do you drink alcohol on a regular basis or have you done so in the past? If yes, please state which drinks and the frequency		
5.	Do you take drugs or have you taken drugs in the past?		
6.	Do you smoke more than 20 cigarettes per day?		
7.	In the last 12 months have you lost more than 5 kg in weight (other than due to a diet)? If so, please provide details		
8.	Have your undergone any laboratory tests such as blood or urine (with abnormal results) or any medical tests including catherisation, echocardiography, endoscopy, invasive tests to detect cancer, biopsy, ECG, x-ray or ultrasound, scans, CT, MRI? If yes, please state the reason, date and result		
9.	Do you or have you suffered from total or partial incapacity to work?		
10.	Are you disabled?		
11.	Do you use any type of medical device?		
12.	Do you suffer from any birth defect?		
13.	Do you suffer from any autoimmune disease including lupus?		
14.	Are you waiting to receive any medical treatment or hospitalisation?		
15.	Are you a carrier of the HIV antibody and/or virus?		
16.	**Gynaecology – women only:**		
	A. Are you pregnant?		
	B. Do you or have you suffered from gynaecological disorders such as: irregular menstruation, infertility, bleeding disorders, uterine diseases, ovarian disorders, abnormal results of gynaecological tests (such as PAP) or any other gynaecological disorders?		
	C. Do you have any breast disorder or breast lumps?		
	D. Have you undergone a Caesarean section?		

Do you or have you suffered from any of the following illnesses or conditions?		**YES**	**NO**
17.	**Neurological disorders** – including vertigo, headaches, migraines, fainting, paralysis, epilepsy, memory disorders, sensory processing disorders, degenerative diseases, stroke, brain haemorrhage, C.V.A., loss of balance, Alzheimer's disease, Parkinson's disease, mental infirmity, dementia, multiple sclerosis.		
18.	**Psychiatric disorders** – any type of disorder or attempted suicide		
19.	**Allergies** – Please provide details of the allergy and any treatment you receive		
20.	**Respiratory disorders** – including asthma, tuberculosis, recurrent pneumonia, cystic fibrosis, bronchitis, emphysema, recurrent infections in the respiratory tract, COPD, pneumothorax		
21.	**Heart and blood pressure disorders** – including angina, heart attack, arrythmia, heart valve disease, congenital heart disease, perimyocarditis, heart disease, high blood pressure or blood pressure fluctuations		
22.	**Cardiovascular disorders** – including hypercoagulation, deep vein thrombosis, varicose veins, cardiovascular		

	disease, peripheral vascular disease		
23.	**Digestive system** – including peptic disorders (peptic ulcers or duodenal ulcers), heartburn, infectious diseases of the intestines, Crohn's disease, ulcerative colitis, gastrointestinal haemorrhage, haemorrhoids, anorectal disorders, liver disorders or liver disease, jaundice, gall bladder infection, gallstones, oesophageal disorders, pancreatic infections		
24.	**Hernia** of any type including incisional hernia		
25.	**Kidney and urinary tract infections** – including kidney stones, kidney or urinary tract infections or obstructions, blood or protein in urine, chronic kidney disease, kidneys cysts, prostate problems		
26.	**Joints and bone –** including arthritis, gout, back, spine, knee and other joint disorders, fracture surgery, bone diseases		
27.	**Metabolism and immune system** – including diabetes, thyroid disorders, disorders of the adrenal gland, pituitary gland, lymph gland, salivary gland or other glands, hyperlipaemia, blood disease or clotting, anaemia		
28.	**Malignant diseases** (**cancer**) – including malignant or pre-malignant tumours, or pre-malignant illnesses. Please state the type, date of diagnosis and treatment.		
29.	**Dermatology and venereology –** including skin growths, psoriasis, herpes, syphilis, warts, papilloma / condyloma		
30.	**Eye disorders and diseases** – including cataract, squinting, blindness, cornea or reticulum problems, distorted vision, astigmatism, glaucoma		
31.	**Ear nose and throat** – including recurrent infections, rhinosinusitis, polyps, tonsilitis, hearing disorders, sleep apnoea, snoring		

Please provide further information concerning any questions to which you have replied "YES". If there is insufficient space please continue on another sheet and attach any medical documentation.

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Signature and date	Name of the insured	Signature of the insured

Information for the proposer
1. In accordance with the policy conditions, the policy can be extended within 90 days after the policy has expired, subject to payment of the premium for the period between the expiry of the policy and the start of the extension (such payment can be made by the insured or the employer) for as long as you stay in Israel as a foreign worker. After 90 days have passed since the policy has expired, a new medical underwriting process will be required.
2. If you suffer from any disability, as defined in the Equal Rights for Disabled Persons Act – 1988, meaning that you suffer from any physical disability, mental or cognitive impairment, whether permanent or temporary, which severely restricts your functioning in typical daily activities, please notify the insurance agent whose details appear in this form.

Declaration of the proposer

1. **I hereby declare, agree and undertake that**: (1) All of the replies are true, complete and have been provided of my own free will. (2) The replies appearing in the declaration of health and any other information supplied to the insurer, together with the insurer's standard conditions in this regard are a fundamental term of the insurance contract between me and the insurer and will form an integral part of the insurance contract. (3) The insurer is free to decide whether to accept or reject this application without having to justify its decision. I know that the insurance contract will take effect only after the insurer confirms acceptance to the insurance in writing and after the first premium has been paid in full.
2. I know that in accordance with this policy the insurer will be exempt from providing any service in connection with any disorder, birth defect or hereditary disease and/or medical condition and/or illness and/or disease and its impact, whether treated or not, directly or indirectly arising from and/or worsened by any medical condition I suffered from before the insurance policy was arranged, subject to the provisions of the Foreign Workers Ordinance and the terms and conditions of the policy.
3. I hereby declare that I have not been refused insurance by any other insurance company.
4. I confirm that I have received information concerning the insurance including a description of the main covers, the insurance premium, the period of insurance, the main sums insured and limits of liability and the possibility of obtaining the full policy wording.
5. By arranging this policy you authorise your insurance agent to submit and receive in your name / for you any notices and/or documents in connection with the underwriting process and the process of arranging this policy.
6. I agree that the insurance policy will be sent to me by the insurance agent whose details appear in this form.
7. **Waiver of medical confidentiality**
   I the undersigned, hereby authorise any health maintenance organisation and/or medical institution and any doctor, hospital or other health facility and/or any insurance company and/or institution and/or entity to supply to Ayalon Insurance Company Ltd. (hereinafter: "the insurance company") all information without exception and in the format requested by the insurance company concerning my medical condition and/or any illness or medical condition affecting me in the past, present or future, and I hereby exempt you from the duty of medical confidentiality and also exempt the insurance company from this duty. This waiver binds me, my heirs and legal representatives and anyone replacing them.

If you wish to obtain the full policy wording and/or any other information concerning the underwriting process and the process of arranging this policy directly from the insurance company, please contact us at any time.

Date of signature	Name of the proposer	Signature of the proposer