Emergency Medical Treatment Authorization/Consent Form
Please fill this form out completely or it will be returned to you to finish.

This form was completed on_____

Child's Full Name _____
Birth Date _____
Child's Age_____
Child's Sex_____

I, _____ parent or guardian of the child named above give my permission to Moise Safra Center Israel Summer Journey to secure and authorize such emergency medical care, emergency dental care and treatment as my child might require while under the Moise Safra Center Staff supervision. I also authorize the Moise Safra Center Israel Summer Journey to administer emergency care or treatment as required, until emergency medical assistance arrives.

NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it would be necessary to have the following information:

Name of Parent or Legal Guardian:_____
Address:_____
Phone Numbers: Home:_____
Cell:_____ Work/School_____
EMAIL: _____
Name of Parent or Legal Guardian:_____
Address:_____
Phone Numbers: Home:_____
Cell:_____ Work/School_____

Doctor (NEED NAME):_____
Doctor's Address (FULL ADDRESS): _____
Doctor's Phone:_____

Dentist (NEED NAME):_____
Dentist's Address (FULL ADDRESS):_____
Dentist's Phone:_____

Present medication(s): _____
Known allergies:_____

Physical on child completed on_____

The following individuals may be contacted in case of emergency and my child may be released to them:

Name:_____
Address:_____
Phone Numbers: Home:_____
Cell:_____ Work/School_____
Relationship to child_____

Name:_____
Address:_____
Phone Numbers: Home:_____
Cell:_____ Work/School_____
Relationship to child_____

Name:_____
Address:_____
Home Phone Numbers: Home:_____
Cell:_____ Work/School_____
Relationship to child_____

Name:_____
Address:_____
Phone Numbers: Home:_____
Cell:_____ Work/School_____
Relationship to child_____

Parent/Legal Guardian's Signature_____Date_____
Parent/Legal Guardian's Signature_____Date_____
Updated…
Parent/Legal Guardian's Signature_____Date_____
Parent/Legal Guardian's Signature_____Date_____

Tour and Care
Insurance Application for Tourists in Israel

Please fill out this form fully and accurately.

HAREL Insurance & Finance

Attn.
Harel Insurance Company Ltd.
Foreign Employees / Tourists Insurance Section
3 Abba Hillel Street, PO. Box 1951, Ramat-Gan 5211802, Fax: 03-7348083
email: fax7930@harel-ins.co.il

Agent's name: .....

Agent's number: .....

I the undersigned (hereinafter, the "Insurance Applicant") ask of "Harel" Insurance Company Ltd. (hereinafter, the "Insurer") to insure me, based on all the content of this Application.

Insurance Period Requested	
From date	To date

A Personal information of insurance applicants (up to the age of 75 years)

	Main Insured	Spouse	Child 1	Child 2	Child 3
Passport number					
First Name					
Last name					
Date of birth					
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of entry to Israel					
Citizenship					
Purpose of visit					
Address					
Mobile phone					
Email for receiving messages, information and promotional material ..... @					

B Provider selection

☐ Harel's private arrangement ☐ Clalit Health Services [HMO]

C Health Statement

The Health Statement below shall apply severally to each one of the following: the main Insured, the spouse and each one of the children insured. Please answer the questions below by marking (✔) in the column of the correct answer. If the answer to any of the questions is "Yes", you must attach an up-to-date report from the attending physician regarding the stated problem, test results, the manner of treatment and the current condition.

	Part A: Investigation of a medical symptom or illness that has not been completed:	Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	During the last two years have you been referred for any of the following medical and/or diagnostic examinations that are not yet completed and regarding which no **final diagnosis has been made yet**: catheterization, mapping, echocardiography, CT, MRI, ultrasound (not as part of routine prenatal monitoring), biopsy, occult blood, colonoscopy, gastroscopy, blood tests, urine tests.										
	Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:	Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	**The nervous system (neurology) and the brain:** ☐ The nervous system ☐ Cerebrovascular accident (CVA) ☐ Multiple sclerosis ☐ Muscular dystrophy										
2	Renal failure										
3	**The respiratory system:** ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Cystic Fibrosis										
4	Malignant disease or tumor (cancer)										
5	**Immune system diseases:** ☐ AIDS and/or HIV carrier ☐ Lupus										

Please specify (only if you answered "yes" to one of the questions in the Statement): .....

.....

.....

For your information - the policy does not provide coverage for a pre-existing medical condition.

StudioHarel b980/14797

D Insurance Applicant's Statement

1. a. The information included in this document is required for your joining the policies and for all other matters and issues pertaining to the policies and the handling thereof. The Company and other companies of the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) and/or anyone on their behalf will make use of it, including the processing, storage and use thereof, for any matter pertaining to the policies and for other legitimate purposes, including by providing the information to third parties acting in the name and on behalf of the Harel Group.
   b. I/we hereby declare that all the answers are correct and complete and are provided out of my/our own free will.
   c. The answers specified in the Health Statement and any other information to be submitted to the Company as well as the Company's customarily prevailing terms and conditions in this matter shall be essential terms, conditions of the insurance contract between you and the Company, and constitute an inseparable part thereof.
   d. The Company may decide to either accept or reject the Application. For your information, the insurance contract shall come into force only after the Company issues a written confirmation of admission of all the insurance applicants.
   e. This consent and statement, including the Health Statement above, shall also apply to the children whose names are listed in the Application and your signature/s on the documents is made also in their names as their guardian.
   Are you authorized to sign these documents on their behalf? ☐ Yes ☐ No.

For your information:

2. Preexisting medical condition: an insurance event, substantially caused by the normal course of a preexisting medical condition, which occurred to the Insured during the period in which a restriction applies. A restriction because of a preexisting medical condition, concerning an insured whose age at the beginning of the insurance period is:
   1. Less than 65 years - Shall apply for a period not exceeding one year from the beginning of the insurance period.
   2. 65 years or more - Shall apply for a period not exceeding half a year from the beginning of the insurance period.
3. This medical insurance is subject to a qualification period of 48 hours.
4. I am aware that the insurance contract shall come into force only after the Company issues a written confirmation of admission regarding the Insurance Applicant. In any case, the insurance period shall begin from the date of confirmation by the Insurer, as said above.
5. **Waiver of medical confidentiality:** I, the undersigned, hereby give permission to the HMO (kupat holim) and/or its medical institutions and/or the all other physicians and psychiatrists, medical institutions and hospitals, and/or any other insurance company and/or any institution and other party, insofar as necessary in order to examine the rights and obligations according to the policy and/or for the purpose of the procedure of examining of my acceptance for the insurance requested, to provide Harel with all the information and details held by the company, without exception, in the form requested by the Requester/s, regarding my health condition, including any disease that I suffered from in the past and/or that I suffer now and/or that I will suffer in the future, and I relieve you from the duty of maintaining medical confidentiality and waive confidentiality in favor of the "Requester." This waiver is binding of my/our estate and my legal representatives and anyone substituting for me.

E Insurance Applicant's Signature

	Date	Name of Insured	ID No.	Signature
Main Insured				
Spouse				
Child over the age of 18 years				
Child over the age of 18 years				
Child over the age of 18 years				
Witnessed the signing (the insurance agent)	Date	ID	Full name	Signature

StudioHarel b980/14797