MEMBERSHIP APPLICATION FORM

FOR THE PROVISION OF MEDICAL SERVICES TO FOREIGN MEMBERS

For internal use only

Registration group

Name of Meuhedet representative

Signature and stamp of the representative

1 DETAILS OF THE INSURANCE APPLICANT

Last name	First name	Passport / ID no.	Date of birth	e-mail	☐ Male ☐ Female
Address in Israel		Place of work / study	Zip code	Telephone _____ Mobile phone _____	

2 SPOUSE'S / PARTNER'S DETAILS

Last name	First name	Passport / ID no.	Date of birth	e-mail	☐ Male ☐ Female	Telephone	Mobile phone

3 FAMILY MEMBERS

Relationship	Last name	First name	Passport / ID no.	Date of birth	☐ Male ☐ Female
Relationship	Last name	First name	Passport / ID no.	Date of birth	☐ Male ☐ Female
Relationship	Last name	First name	Passport / ID no.	Date of birth	☐ Male ☐ Female
Relationship	Last name	First name	Passport / ID no.	Date of birth	☐ Male ☐ Female

4 TYPES OF REQUESTED COVERAGE

☐ Joining the basic package ☐ Joining additional plans

Extension of coverage for additional health services	Meuhedet Adif	Meuhedet Si
Name of applicant		
Name of applicant		
Name of applicant		
Name of applicant		
Name of applicant		

The insurance coverage shall enter into effect on the first of the month following the approval of acceptance to the plan by Meuhedet or the approval of the terms declared by Meuhedet if asked to approve them, the later of the two.

5 DECLARATION OF THE INSURANCE APPLICANTS

This declaration refers to each of the insurance candidates listed in this offer form. I hereby request to join the program for health services for foreign insureds and/or additional health services, in the framework of Meuhedet (hereinafter: "the Plan") according to the above-detailed (based on this offer).
Please note that the plan's entry into force will be subject to your signature on the full health declaration and provided that Meuhedet approves your acceptance to the plan.
Your answers and/or information provided to the insurer will be maintained in a database in accordance with the instructions of the Privacy Protection Law of 1981 and will serve for the purposes of the insurance only.

a. I hereby declare, agree, and undertake that:

1. All answers as detailed in the Offer and Health Declaration are complete and correct and were provided of my free will.
2. The answers detailed in the Offer and the Health Declaration and any other information provided to Meuhedet (hereinafter: the HMO) as well as the customary conditions of Meuhedet for this matter, will serve as fundamental conditions for the contract between us and will constitute an inseparable part thereof.
3. I am/we are aware that my rights in the framework of the plan will enter into force after Meuhedet issues a written confirmation of the candidate's acceptance to the plan, provided that the premium for the first 4 months have been paid in full.
4. I am aware that the membership fees are collected by Meuhedet. The membership fees may be collected in the future by another corporation on behalf of Meuhedet and I shall have no claims regarding the identity of the corporation collecting the fees.

b. Please note: this plan has limitations regarding the health conditions of its members – please thoroughly review the plan's guidelines. The binding version is the Hebrew language version.

6 HEALTH DECLARATION

Please indicate 'N' for no and 'Y' for yes. When selecting 'Y' please use the table to provide additional details, and attach the appropriate medical documents:

	Question	Please indicate N for no and Y for yes	Comments: if you indicated Y, please provide additional details and attach medical documents
1.	Height in meters		
2.	Weight in kg		
3.	Do you smoke? If yes, how long (in years) have you been smoking? How many cigarettes a day?		
4.	Are you sick now, or have you been ill over the last year? Please detail the illness and its time of occurrence.		
5.	Are you fully or partially prevented from carrying out one or more of the following activities independently: sitting, standing , walking, showering, dressing, eating, drinking, or bowel continence?		
6.	Have you ever been hospitalized at a hospital or any other medical institution? Please state the date, reason for hospitalization and the treatment you received.		
7.	Have you undergone lab tests and/or any medical tests over the last year? Please detail cause, time and results		
8.	Have you undergone surgery? Please describe the time and nature of surgery		
9.	Have you taken, or are you currently taking medication regularly? Please provide details		
10.	Have you undergone any special tests over the last 6 years such as MRI, CT, bone scintigraphy or mammography? Please detail when and why.		
11.	Do you consume drugs or alcohol?		
12.	Have you received special services for treatment at home?		
13.	Have you been injured by a work / car / other accident?		
14.	Do you receive a disability / nursing stipend from any entity whatsoever?		
15.	Have you been under medical / developmental / psychological / psychiatric follow-up?		
16.	Are you suffering or have you suffered in the past from a birth defect / genetic (hereditary) disease or temporary / permanent disability?		
17.	Do you suffer from any active or dormant chronic disease whatsoever?		
18.	Are you suffering from or have you suffered in the past from any infectious disease whatsoever?		
19.	Have you lost 6 or more kg over the last six months?		
20.	Are you suffering from exhaustion or chronic exhaustion?		
21.	Metabolic / hormonal (endocrinological) illnesses including diabetes, hyperlipidemia, gout, Gaucher's disease, FMF, thyroid gland, parathyroid gland, pituitary gland (prolactinoma / prolactinemia), growth disorders		
22.	Nervous system, brain and / or developmental disabilities including epilepsy, cerebrovascular accident (CVA), brain tumor, multiple sclerosis, muscular dystrophy, tremor, Parkinson's disease, paralysis, polio, Asperger syndrome, autism, attention deficit disorder, dizziness and fainting		
23.	Mental illnesses, including depression, anxieties, post-traumatic stress disorder. Have you been diagnosed with a mental illness?		
24.	Malignant diseases, tumors including: benign tumor, cancerous tumor, and pre-cancerous tumor		
25.	Lung and respiratory tracts: including; asthma, bronchitis, COPD (Obstructive pulmonary disease), emphysema, sarcoidosis, sleep apnea, cystic fibrosis, pneumonia, tuberculosis		
26.	Visual system including: visual disability above number 7, retinal detachment, glaucoma (intraocular pressure), cataract, uveitis, keratoconus, and blindness		
27.	Ear-nose-throat system including: hearing loss, Ménière's disease, tinnitus, polyps, vocal chord damage		
28.	Cardiovascular / blood pressure / blood vessel system including: high blood pressure, heart attack, heart failure, congenital heart defect, heart arrhythmia, valve damage, thrombosis, pulmonary embolism, abdominal aortic aneurysm, enlarged veins, pulmonary hypertension, atherosclerosis		
29.	Hernia and digestive system including: hernia of any type, reflux, Crohn's disease, colitis, ulcerative colitis, rectal hemorrhage, rectocele, hepatitis / jaundice, enlarged liver, fatty liver disease, cirrhosis, gallbladder stones, infection in the pancreas (pancreatitis)		
30.	Kidneys and urinary tract including: renal failure, polycystic kidney, kidney or other defect, stones, urinary tract reflux, bladder hernia, blood / protein in the urine, benign hypertrophy prostate, other problems in the prostate		
31.	The blood system, immune system, infectious diseases including: anemia, irregular blood count, disruption to blood coagulation, thalassemia major / intermedia, hemophilia, enlarged spleen, immune system disorders, AIDS / carrier, continuous fever lasting more than 3 months		
32.	Musculoskeletal system and joints including: joint diseases, hernia, dislocation, tendon / ligament damage, disc herniation, osteoporosis, degenerative joint disease, rheumatoid arthritis, lupus, chronic fatigue syndrome		
33.	Skin and venereal system including: psoriasis, pemphigus, eczema, skin lesion and /or tumor, infectious skin disease, papilloma/condyloma		
34.	Reproductive system Men– breast tissue lump / abscess, fertility disorders, testicular tumor, varicocele, hydrocele, hypospadias. Women – breast tissue lump / abscess, irregular bleeding outside of the monthly period, uterine fibroids, ovarian cyst, recurring miscarriage, uterine prolapse and / or vaginal wall prolapse, fertility problems, endometriosis		
35.	Women – are you pregnant? If yes, please attach a letter from a gynecologist including documentation and pregnancy monitoring.		
36.	Do you have a medical condition that is not mentioned in these paragraphs and requires medical investigation?		

7 ARE YOU INSURED IN ISRAEL / OVERSEAS?

☐ Yes ☐ No	Name of company	Name of plan	Insurance period

8 WAIVER OF MEDICAL CONFIDENTIALITY (FOR THE PURPOSE OF ACCEPTANCE TERMS CLAIM OR INQUIRY REGARDING LAWSUIT)

I, the undersigned, hereby grant authorization to all doctors, medical institutions, and other hospitals in Israel and abroad, and to the National Insurance Institute and / or any other institution and entity (hereinafter: "the Medical Institutions") and / or to other insurance companies to provide Meuhedet with all details without exception in the form required by it, as detailed in the documents held by the medical institutions for the purpose of Meuhedet's investigation according to the plan, and I exempt the aforementioned medical institutions from the obligation to maintain medical confidentiality and waive this confidentiality for Meuhedet. This waiver is binding upon myself and shall apply also to my minor children and their legal representatives.
This waiver is binding upon my person and will also be binding upon my heirs and the estate that remains after my death.

9 IN WITNESS WHEREOF I HEREBY AFFIX MY SIGNATURE:

Date	Name of applicant	Passport/ID no.	Applicant's signature

(direct debit from credit card)

ID of the Meuhedet policyholder

Please fill in your credit card information, sign and send to us .

If you choose this option, you do not need to sign for direct debit from your bank account.

Card Number: .....

Card Expiry Date: **Month…….. Year……. CVV/CVC .....**

- I have signed this form without specifying the number of payments or the payment amounts, inasmuch as I have given permission to Meuhedet to charge the credit card company from time to time as will be specified to the issuer.

- This permission shall expire upon notification to Meuhedet.

- This permission shall also be valid for charging a card with a different number issued in place of the card whose number is written on this form.

Name of card holder .....

Date:.....

DD MM YYYY

Signature .....