gov.il

Application number: 832873

Issue date: 12.10.2021

This document is not confirmation that the form has been submitted

Application for an entry permit to Israel during the COVID-19 pandemic for passengers traveling with a foreign passport

Application number: 832873

Request details

Passport number
P3885035

Last Name
Belgaonkar

First Name
Pradyumna Pramod

Mobile phone
+7892548263

Email
pradyumnapb@gmail.com

Copy of the passenger's passport
Passport.pdf

Passport nationality
INDIA

Additional citizenship

Medical status
Vaccinated

Copy of the vaccination certificate
certificate.pdf

Are you holding overseas health insurance that includes medical coverage for COVID-19?

- (●) Yes
- ( ) No

Please attach a copy of the health insurance policy for the visit abroad
HealthInsurance.pdf

Arriving from (country)
India

Which Israeli embassy or consulate are you applying to?
BENGALURU

Are you traveling with other family members who have applied for a permit?

- ( ) Yes
- (●) No

Travel details

Purpose of traveling to the State of Israel
Other

Please specify the reason for the request to travel to Israel
I am accepted to the M.A. program in physics at Hebrew University of Jerusalem

Please indicate if traveling to Israel through other countries (Connection countries)

- ○ No
- ● Yes

Countries

United Arab Emirates

Scheduled flight date

20/10/2021

Are there additional supporting documents to attach/upload?

- ○ No
- ● Yes

Documents

Document 1

Description

Acceptance Letter from the university

Attachment

Acceptance.pdf

Document 2

Description

Quarantine Form

Attachment

QuarantineForm.pdf

Applicant's comments:

इस पासपोर्ट में 36 पृष्ठ हैं। This passport contains 36 pages.

भारत गणराज्य REPUBLIC OF INDIA

टाईप / Type: P
राष्ट्र कोड / Country Code: IND
पासपोर्ट नं. / Passport No.: P3885035

सरनाम / Surname
BELGAONKAR

दिया गया नाम / Given Name(s)
PRADYUMNA PRAMOD

राष्ट्रीयता / Nationality
भारतीय/INDIAN

लिंग / Sex
M

जन्म तिथि / Date of Birth
18/07/1998

जन्म स्थान / Place of Birth
DHARWAD, KARNATAKA

Pradyumna P.B

जारी करने का स्थान / Place of Issue
BENGALURU

जारी करने की तिथि / Date of Issue
09/08/2016

समाप्ति की तिथि / Date of Expiry
08/08/2026

P<INDBELGAONKAR<<PRADYUMNA<PRAMOD<<<<<<<<<<
P3885035<9IND9807187M2608086<<<<<<<<<<<<<<8

विविध सेवा / MISCELLANEOUS SERVICE

P3885035

पिता / कानूनी अभिभावक का नाम / Name of Father / Legal Guardian
PRAMOD VASUDEV BELGAONKAR

माता का नाम / Name of Mother
POORNIMA PRAMOD BELGAONKAR

पति या पत्नी का नाम / Name of Spouse

पता / Address
1989 1 B MAIN 20TH D CROSS C BLOCK SAHAKAR NAGAR
BENGALURU,BENGALURU
PIN:560092,KARNATAKA,INDIA

पुराने पासपोर्ट का नं. और इसके जारी होने की तिथि एवं स्थान / Old Passport No. with Date and Place of Issue

फाईल नं./ File No.
BN2069495929916

प्रेक्षण / OBSERVATION

For your peace of mind | HAREL Insurance & Finance

Policy Schedule - Tour & Care Insurance Policy

Policy Number:	585016304421	Print Date:	2/09/2021
Branch:	585	Offer Date:	10/10/2021
Type of Program:	Tour&Care	Clalit Medical Service Number:	74300443384
Agent:	40219 ידידים הסדרים פנסיונים	Collective:	האוניברסיטה העברית מנהל
Email:		Occupation:	Student

Insurance Period	From	10/10/2021	To	9/10/2022
Total insurance days	365			

All Medical Services will be given by the "Clalit Medical network".
Call Center to arrange appointment at "Clalit" 1-222-2700 / *2700

For 24/7 doctor on call service dial 1800260660

Policy Holder:

Policy Holder	I.D. / Passport	Telephone
האוניברסיטה העב 5149 מנהל	500701610	058 - 6919994

Email: simaa@savion.huji.ac.il **Address:** הר הצופים 11111ירושלים

Insured:

First Name	Last Name	Passport	Birth Date	Country of Citizenship	Gender
PRADYUMNA	BELGAONKAR	P3885035	18/07/1998	INDIA	MALE

Email: pradyumnapb@gmail.com **Telephone No:** 000 -

Deductible:

The deductible that the Insured will pay, insofar as it is charged, will be according to that set by the service provider in the Policy (the HMO - Kupat Holim).

Details of the Coverage:

Coverage	From	To	Cost [ILS]
Basic coverage	**10/10/2021**	**9/10/2022**	**4842.09**
Medical expenses overseas	**10/10/2021**	**9/10/2022**	**0.00**
Medical expenses in Israel as a result of an emergency psychiatric event	**10/10/2021**	**9/10/2022**	**0.00**
Expenses of air evacuation from the location of the event in Israel to a nearby hospital	**10/10/2021**	**9/10/2022**	**0.00**
Emergency flight for a close relative	**10/10/2021**	**9/10/2022**	**0.00**
Extreme sports	**10/10/2021**	**9/10/2022**	**0.00**
Medical flight	**10/10/2021**	**9/10/2022**	**0.00**
Death or loss of limbs or organs (in Israel only)	**10/10/2021**	**9/10/2022**	**0.00**

The Policy covers COVID-19 in accordance with and subject to the terms of the Policy and the underwriting policy of the Company.

Premium Calculation:

Insurance Payment Calculation [ILS]	Basic Premium	Additional	Discounts	Total Payment
	4,842.09	**.00**	**.00**	**4842.09**

Private Charging:
The policy will be charged using the means of payment disclosed during the purchase process

Despite the specified in the terms of policy, please note that in accordance with the provisions of Section 31 of the Insurance Contract Law 5741-1981, as of 25/11/2020, the statute of limitations for insurance benefit claims for disease and hospitalization insurance is five years.

For your peace of mind | HAREL Insurance & Finance

A Health Statement

Passport No.	Last name	First name	Date of birth	Sex
P3885035	BELGAONKAR	PRADYUMNA	18/07/1998	Male

Is the purpose of the trip for one or more of the travelers is to receive a medical care?	Yes	No
		✓

If the answer to Question 1 is yes, we cannot accept you in the insurance.

Section A: General Questions		Yes	No
1.	☐ Do you use, or have you been using narcotics? ☐ Do you drink, or have you been drinking alcoholic beverages regularly? Please specify the quantity of consumption: ..... glasses per day.		✓
2.	During the last 5 ears, have you been referred to any of the following examinations (other than as part of routine checkups) and not yet taken it, or not yet had a final diagnosis determined for you, such as: chronic illnesses, catheterization, bone mapping, echocardiography, MRI, CT, ultrasound (other than as part of routine prenatal care), biopsy, occult blood, colonoscopy or gastroscopy, autoimmune diseases including lupus (if "Yes", please submit a certificate from the attending physician, stating the reason for performing the examination, the examination outcomes and final diagnosis).		✓
3.	Are you now, or have you been sometime during the last 5 years, about to undergo a surgery/ transplantation? Please describe in details:		✓
4.	During the last 5 ears, have you been hospitalized? Please describe in details the reason for hospitalization and the treatment that you have received.		✓
5.	During the last 5 years, have you been taking, or have you received a recommendation to take, medications regularly? Please describe in details the problem for which you are treated / have been treated, the treatment, and for how long have you been taking the said medication?		✓
6.	Have you been diagnosed as suffering from any allergies? Please describe in details:		✓
Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:		**Yes**	**No**
1.	☐ The nervous system ☐ Cerebrovascular accident (stroke) ☐ Epilepsy ☐ Multiple sclerosis ☐ Muscular dystrophy or other atrophic disease ☐ Reoccurring dizziness ☐ Headaches ☐ Balance disorders ☐ Fainting ☐ Parkinson's syndrome ☐ Alzheimer's disease ☐ Trembling ☐ Mental retardation ☐ Autism ☐ Down's syndrome ☐ Cerebral palsy ☐ Poliomyelitis (infantile paralysis) ☐ Gaucher's disease ☐ Loss of sensation (numbness) ☐ Attention deficit disorders ☐ Migraine ☐ Have you applied to a physician with complaints regarding declined memory (dementia) ☐ AIDS ☐ HIV carrier ☐ Lupus **If the answer to one or more of the questions above is "Yes", please attach an up-to-date letter from the attending neurologist.**		✓
2.	**Eyes and vision:** ☐ Cataract ☐ Retina and cornea problems ☐ Glaucoma ☐ Inflammations of the eye ☐ Strabismus ☐ Blindness Other eye disease / problem: ☐ No ☐ Yes, if "Yes" please specify:		✓
3.	**Heart:** ☐ Cardiac arrhythmias ☐ Heart disease ☐ Heart failure ☐ Heart attack ☐ Congenital heart defect ☐ Catheterization ☐ Heart valve diseases, other heart disease / problem: ☐ No ☐ Yes, if "Yes" please specify:		✓
4.	**Blood vessels:** ☐ Varicose vein (in the veins of the legs) ☐ Carotid artery (in the arteries of the neck) ☐ Coagulation disorders ☐ Blood disease DVT (Thrombosis) ☐ PVD (Peripheral Vascular Disease), other vascular disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓
5.	**Metabolic diseases:** ☐ Thyroid gland ☐ Lymph node ☐ Salivary gland ☐ Sweat gland ☐ Pituitary gland ☐ Diabetes ☐ Hypertension ☐ High levels of fats/cholesterol, other metabolic disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓
6.	**Respiratory system:** ☐ Asthma ☐ Tuberculosis ☐ COPD (chronic obstructive pulmonary disease) ☐ Hay fever ☐ Recurrent respiratory infections and Shortness of breath ☐ Collapsed lung (Pneumothorax) ☐ Cystic Fibrosis Other respiratory system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓

For your peace of mind | HAREL Insurance & Finance

A Health Statement - continue

	Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:	Yes	No
7.	**Digestive system:** ☐ Ulcer (duodenum / gastric) ☐ Heartburn ☐ Crohn's disease ☐ Colitis ☐ Reflux ☐ Hemorrhoids ☐ Fissure / Fistula ☐ Bowel obstruction ☐ Pancreatic diseases / infections ☐ Esophagus ☐ Gallbladder ☐ Gall-bladder stones Other digestive system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓
8.	**Liver:** ☐ Jaundice ☐ Hepatitis B, C, D ☐ Fatty liver ☐ Cirrhosis, other digestive system disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓
9.	**Hernia:** Location of the hernia: In the diaphragm / in the navel / in the right groin / in the left groin Have you undergone a surgery to treat the hernia? ☐ No ☐ Yes, when (date)? ..... Is the problem solved? ☐ No ☐ Yes		✓
10.	**Kidney and urinary tract:** ☐ Recurrent infections ☐ Kidney and urinary stones ☐ Kidney cysts ☐ Anomalies of urinary tract ☐ Renal failure, other kidney and urinary tract disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓
11.	**Joints and bones:** ☐ Arthritis ☐ Gout ☐ Back / spine ☐ Joints ☐ Knees Other joints and bones disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓
12.	**Skin and sex diseases:** ☐ Skin tumors ☐ Skin lesions ☐ Psoriasis ☐ Sexually transmitted diseases ☐ Syphilis Other skin and sex diseases disease / problem ☐ No ☐ Yes, if "Yes" please specify:		✓
13.	Malignant tumors / diseases (cancer).		✓

Date Applicant's Signature : 24/08/2021

It is hereby clarified that based on the answers in the Health Declaration, you have been accepted to the insurance plan with no restrictive terms due to underwriting.

For your peace of mind | HAREL Insurance & Finance

Sep, 02, 2021

To Whom It May Concern:

RE: **Medical Insurance for Tourists**

We hereby confirm that the Insured whose name is listed below is insured under medical insurance in our company from 10/10/2021 To 9/10/2022, subject to the full terms of the policy.

Name of Insured: PRADYUMNA BELGAONKAR

Policy number: 585016304421

Passport number: P3885035

Clalit Medical Service Number: 74300443384

Sincerely,

Harel Insurance Company Ltd.

It is hereby clarified that:

1. The full and binding terms are set forth in detail in the terms of the policy. In the case of conflict between the terms of the policy and the terms specified on the Insurance Details Page, the terms specified on the Insurance Details Page will prevail.
2. If you requested to purchase coverage in addition to the Basic Policy, you may cancel any of the coverages at any time without the cancellation being conditional upon cancellation of any one or more of the other coverages that you purchased together with the Basic Policy, and without cancellation of the coverages causing cancellation of a discount on the Basic Policy or another coverage. This is with the exception of cancellation of a reduced price that was given because of the purchase of several different coverages that were priced together in advance. In the case of cancellation of the basic Policy the additional coverages that accompanied the Basic Policy will also be cancelled.
3. The details of how to submit a claim to the Company can be found on the website of Harel Insurance Company Ltd., at https://www.harel-group.co.il
4. The privacy policy of the Harel group is available to you on the Company website.
5. Harel operates a central database that includes information from the different institutional organizations of the Group for the purposes of research, adiministration and in order to offer you different services and products suited to your needs, based on the information collected by the institutional organization in the Group. To read more about the privacy policy of the Group see out website www.harel-group.co.il where you may also notify us that you are not interested in certain uses and processing of information.

האוניברסיטה העברית בירושלים
THE HEBREW UNIVERSITY OF JERUSALEM

10.10.2021

To whom it may concern,

We hereby to declare that Mr. Belgaonkar Pradyumna Pramod, passport number P3885035 has been accepted to an MA program in the Department of Physics, the Faculty for Nature Science at the Hebrew University of Jerusalem for the 2021-22 academic year (10/10/2021-24/6/2022).

We kindly ask you to provide Mr. Belgaonkar Pradyumna Pramod with a student visa (A2).

Sincerely,

Jane Turner
Head of International Office

The International Office
Mount Scopus
Jerusalem 91905, Israel
Tel. 972-2-5881914
Fax. 972-2-5883021
janet@savion.huji.ac.il

המשרד הבינלאומי
הר הצופים
ירושלים 91905
טלפון: 02-5881914
פקס: 02-5883021
janet@savion.huji.ac.il

सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

Certificate for COVID-19 Vaccination

Fully Vaccinated : **2nd Dose**

Beneficiary Details

Beneficiary Name / ಫಲಾನುಭವಿಯ ಹೆಸರು	**Pradyumna P Belgaonkar**
Age / ವಯಸ್ಸು	**23**
Gender / ಲಿಂಗ	**Male**
ID Verified / ಐ.ಡಿ. ಗುರುತು	**Passport # P3885035**
Unique Health ID (UHID)	
Beneficiary Reference ID	**92801851608030**

Vaccination Details

Vaccine Name / ಲಸಿಕೆ ಹೆಸರು	**COVISHIELD**
Date of 1st Dose / ಮೊದಲ ಡೋಸ್ ದಿನಾಂಕ	**05 Jun 2021 (Batch no. 4121Z082)**
Date of 2nd Dose / ಎರಡನೇ ಡೋಸ್ ದಿನಾಂಕ	**11 Aug 2021 (Batch no. 4121Z084)**
Vaccinated by / ಲಸಿಕೆ ನೀಡಿದವರು	**CHAYA BAI**
Vaccination at / ಲಸಿಕೆ ಹಾಕಿದ ಸ್ಥಳ	**93 Central College EZ, BBMP, Karnataka**

“ಔಷಧಿ /ಲಸಿಕೆ ಬೇಕು,
ಜೊತೆಗೆ ದೃಢತೆ ಬೇಕು
Together, India will defeat COVID-19”

- ಪ್ರಧಾನಮಂತ್ರಿ ನರೇಂದ್ರ ಮೋದಿ

In case of any adverse events, kindly contact the nearest Public Health Center/ Healthcare Worker/District Immunization Officer/State **Helpline No. 1075**

ಯಾವುದೇ ಅಡ್ಡಪರಿಣಾಮ ಉಂಟಾದ ಸಂದರ್ಭದಲ್ಲಿ, ದಯವಿಟ್ಟು ಸಮೀಪದ ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರ/ಆರೋಗ್ಯ ಶುಷ್ರೂಷೆ ಕಾರ್ಯಕರ್ತೆ/ ಜಿಲ್ಲಾ ಲಸಿಕೆ ಅಧಿಕಾರಿ/ರಾಜ್ಯ ಸಹಾಯವಾಣಿ ಸಂ. 1075 ಸಂಪರ್ಕಿಸಿ

COWIN
Winning Over COVID

This certificate can be verified by scanning the QR code at http://verify.cowin.gov.in

www.health.gov.il

משרד הבריאות
לחיים בריאים יותר

ראש שרותי בריאות הציבור
Director of Public Health Services

הנדון: התחייבות בקשר לקבלת אישור כניסה פרטני למדינת ישראל

הואיל ופנית בבקשה לקבלת אישור פרטני לכניסה לישראל, מצ"ב טופס התחייבות לחתימתך המהווה תנאי לאישור הכניסה.

Subject: obligations regarding individual permission to enter The State of Israel

–

As you have applied for an individual permit to enter Israel, attached is a commitment form for your signature, which is a condition for approval.

Name of the undersigned Pradyumna. P.B שם החתום\ה מטה:

ID or Passport number P3885035 ת"ז או דרכון:

Telephone number (where you can be reached in Israel) 02-6584550 טלפון:

place of Isolation Full address Lohamei Hayetot 2 Jerusalem מקום הבידוד (כתובת מלאה):

Name of host International Office HUJI שם המארח

host number phone 02-5882924 מספר טלפון של המארח

אני החתום\ה מטה מתחייב\ת בזאת לעמוד בתנאים המפורטים להלן:

I, the undersigned, hereby guarantee that the applicants, who are not residents of Israel, comply with the following conditions:

1. אני מכיר\ה את ההנחיות לבידוד בית המפורסמות באתר משרד הבריאות
Applicants are familiar with the guidelines for home isolation available on the Ministry of Health website.

2. אני מתחייב\ת לפעול בהתאם להנחיות המפורסמות באתר משרד הבריאות
Applicants have pledged to follow the guidelines published on the Ministry of Health website.

3. אני מתחייב\ת לדווח למשרד הבריאות על שהותי בבידוד בית באתר:
I undertake to report my home isolation to the ministry of health at:

https://govforms.gov.il/mw/forms/HouseIsolation@health.gov.il

www.health.gov.il

משרד הבריאות
נחיים בריאים יותר

ראש שרותי בריאות הציבור
Director of Public Health Services

4. אני מתחייב\ת כי הנסיעה משדה התעופה לדירה בה ישהו בבידוד תהיה ברכב פרטי בלבד (ולא בתחבורה ציבורית, ובכלל זה מונית).
Applicants will travel from the airport to the address where they will stay in isolation only by private vehicle (and not by public transport, including taxis).

5. אני מתחייב\ת למדוד חום גוף מדי יום במהלך 14 הימים החל מיום הנחיתה בארץ.
Applicants will measure body tempurature daily during the 14 days from the date of landing in the country.

6. בכל מקרה של **הופעת חום מעל 38 מעלות, שיעול, קושי בנשימה או תסמין נשימתי אחר**, אני מתחייב\ת לדווח באופן מיידי למשרד הבריאות באמצעות מוקד מד"א 101
In the event of a fever above 38 degrees, or coughing, or difficulty breathing or other respiratory symptoms, applicants should immediately report to the Health Ministry by 101

חתימה: Pradyumna D.B
תאריך: 11/10/2021