

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

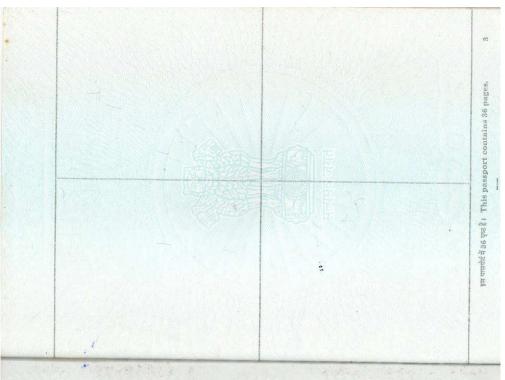
Application number: 832873

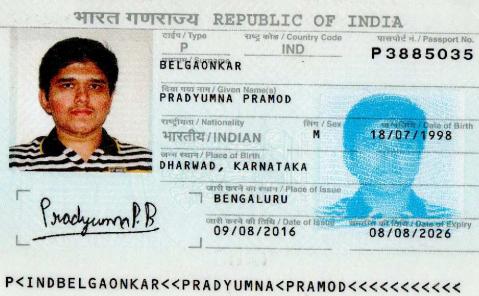
Request details

Passport number	Last Name	First Name
P3885035	Belgaonkar	Pradyumna Pramod
Mobile phone	Email	
+7892548263	pradyumnapb@gmail.co	m
Copy of the passenger's passport	Passport nationality	
Passport.pdf	INDIA	
Additional citizenship	Medical status	Copy of the vaccination certificate
	Vaccinated	certificate.pdf
Are you holding overseas health ins	surance that includes medical c	overage for COVID-19?
Yes		No
Arriving from (country)	Which Israeli embassy or o	consulate are you applying to?
Arriving from (country)	Which Israeli embassy or o	consulate are you applying to?
India	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 re	equest to travel to Israel	
I am accepted to the M.A. program	in physics at Hebrew University	of Jerusalem

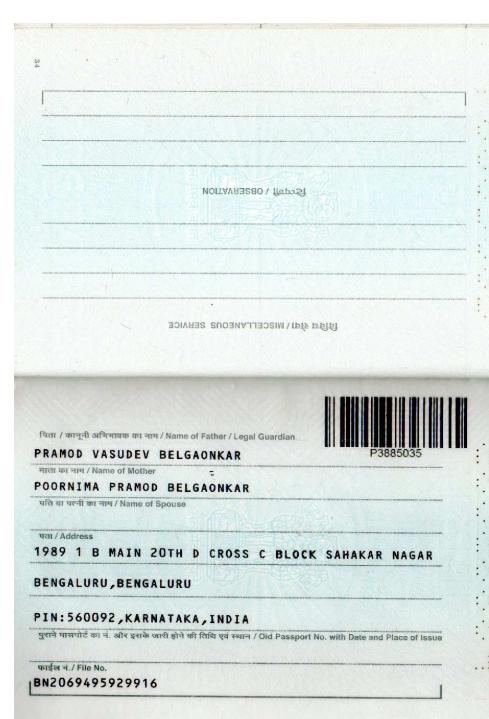
)	No	Yes
ountries		
United Arab Emirates		
cheduled flight date		
20/10/2021		
	rting documents to attach/upload	
)		
	No	Yes
Documents Document 1 Description	No	Yes
Documents Document 1	No	Yes
Documents Document 1 Description	No	Yes
Documents Document 1 Description Acceptance Letter from Document 2	No	Yes
Documents Document 1 Description Acceptance Letter from	No	Attachment Acceptance.pdf

This form contains information protected by the Privacy Protection Act.





P3885035<9IND9807187M2608086<<<<<<<







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:	ידידים הסדרים פנסיונים 40219	Collective:	האוניברסיטה העברית מנהל
Email:		Occupation:	Student

Insurance Period	From	10/10/2021	То	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
מנהל 5149 האוניברסיטה העב	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).

HealthInsurance.pdf

4/13



לצפייה **בתנאי הפוליסה** המלאים

קוד מסמך 33509

מספר עמוד: 1 מתוך: 6





Details of the Coverage:

Coverage	From	То	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.



לצפייה **בתנאי הפוליסה** המלאים

קוד מסמך

מספר עמוד: 2 מתוך: 6

585016304421





		alth Statement					
		ssport No.	Last name	First name	Date of birth	Sex	
		85035	BELGAONKAR	PRADYUMNA	18/07/1998	Ma	
	IS LI	ne purpose of the trip) for one or more of the	e travelers is to receive a m	ledical care?	Yes	No /
	If t	he answer to Questio	n 1 is yes, we cannot ac	cept you in the insurance.			
	Sed	ction A: General Ques				Yes	No
	1.	alcohólic beverages	regularly?	otics? Do you drink, or ha : glasse	,		1
	2.	During the last 5 ear part of routine check such as: chronic illne (other than as part of autoimmune disease	rs, have you been referre kups) and not yet taken isses, catheterization, b of routine prenatal car es including lupus (if "	ed to any of the following e it, or not yet had a final dia one mapping, echocardiog e), biopsy, occult blood, co Yes", please submit a certi	syaminations (other than as gnosis determined for you, graphy, MRI, CT, ultrasound blonoscopy or gastroscopy, ficate from the attending xamination outcomes and		1
	3.	transplantation?		during the last 5 years, ab	out to undergo a surgery/		1
-	4.	Please describe in de During the last 5 e hospitalization and t		ospitalized? Please describe have received.	e in details the reason for		1
	5.	medications regularl	ly? Please describe in c	ng, or have you received a details the problem for wh ong have you been taking	recommendation to take, ich you are treated / have the said medication?		1
	6.	,	nosed as suffering from	, ,			1
	Par			se, syndrome, disorder rela	ted to one or more of the	Yes	No
		☐ The nervous systemuscular dystrophy disorders ☐ Fainting retardation ☐ Autism ☐ Gaucher's disease Have you applied to ☐ HIV carrier ☐ Lupulf the answer to one from the attending results.	or other atrophic disea g Parkinson's syndr m Down's syndrome Loss of sensation (no a physician with comp is or more of the questineurologist.	ome Alzheimer's diseas Cerebral palsy Polior umbness) Attention defi laints regarding declined n ons above is "Yes", please a	ss ☐ Headaches ☐ Balance e ☐ Trembling ☐ Mental myelitis (infantile paralysis) cit disorders ☐ Migraine ☐ nemory (dementia) ☐ AIDS		1
	2.	the eye Strabismu Other eye disease / p		·	ma □ Inflammations of		1
	3.	heart defect 🗌 Cath	eterization 🗌	ease □Heart failure □ He roblem: □No □Yes, if "Ye	_		1
	4.	neck)	n disorders 🗌 Blood di: lar disease / problem 🗀	sease DVT (Thrombosis) ☐]No☐Yes, if "Yes" please	tery (in the arteries of the] PVD (Peripheral Vascular		1
	5.	gland □ Diabetes □ problem □ No □ Ye] Hypertension □ Highes, if "Yes"	ph node			1
	6.	Respiratory system: I disease) Hay fever lung (Pneumothorax	☐ Asthma ☐ Tuberculo ☐ Recurrent respirato () ☐ Cystic Fibrosis tem disease / problem	osis	ructive pulmonary		1



33509 קוד מסמך





Α	не	aith Statement - continue				
	Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issue listed below:					
	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:				
		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)?		1		
	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:		1		
Ì	11.	Joints and bones: Arthritis Gout Back / spine Joints Knees Other joints and bones disease / problem No Yes, if "Yes" please specify:		1		
	12.	No ☐ Yes, if "Yes" please specify: 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).		1		

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.



585016304421





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.



קוד מסמך 33509



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.



33509



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,

Jan Turners 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



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 / ಲಿoಗ 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"

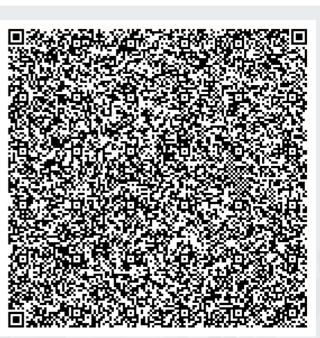
- ಪ್ರಧಾನಮಂತ್ರಿ ನರೇಂದ್ರ ಮೋದಿ

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







www.health.gov.il



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, מצייב טופס התחייבות לחתימתך המהווה תנאי

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.

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

ID or Passport number <u>P3895035</u> : תייז או דרכון

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

place of Isolation Full address Lohame Hogetot 2 (מקום חבידוד (כתובת מלאת)

Terusalem

Name of host Internalianal Office HUII שם המארח

מספר טלפון של המארח ארם 12 host number phone <u>02-588292</u>

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:

- 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.
 - אוי מחחיירות לפעול בהתאם להוחיות 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/Houselsolation@health.gov.il

www.health.gov.il



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

Prodyumno B : Incan: