



Policy Schedule - Tour & Care Insurance Policy

Policy Number:	585016416621	Print Date:	9/09/2021
Branch:	585	Offer Date:	1/10/2021
Type of Program:	Tour&Care	Clalit Medical Service Number:	74300444242
Agent:	ידידים הסדרים פנסיונים 40219	Collective:	האוניברסיטה העברית משפחות
Email:		Occupation:	Student

Insurance Period	From	1/10/2021	To	30/09/2022
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

Insured:

First Name	Last Name	Passport	Birth Date	Country of Citizenship	Gender
TRESA	GEORGE	M8389530	30/06/1986	INDIA	FEMALE

Email: tresa.george@mail.huji.ac.il

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).



^dt33509



Details of the Coverage:

Coverage	From	To	Cost [ILS]
Basic coverage	1/10/2021	30/09/2022	4842.09
Worsening of a preexisting illness	1/10/2021	30/09/2022	0.00
Pregnancy and childbirth three months waiting period	1/10/2021	30/09/2022	0.00
Medical expenses overseas	1/10/2021	30/09/2022	0.00
Medical expenses in Israel as a result of an emergency psychiatric event	1/10/2021	30/09/2022	0.00
Psychological treatments	1/10/2021	30/09/2022	0.00
Expenses of air evacuation from the location of the event in Israel to a nearby hospital	1/10/2021	30/09/2022	0.00
Emergency flight for a close relative	1/10/2021	30/09/2022	0.00
Extreme sports	1/10/2021	30/09/2022	0.00
Physical therapy	1/10/2021	30/09/2022	0.00
Medical flight	1/10/2021	30/09/2022	0.00
Contact with radioactive materials	1/10/2021	30/09/2022	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:

Identification of the person making the payment	Name of person making the payment	Number of payments	Card Number
4449607	.GEORGE P.A	1	*****5005
Total to be charged	Your account will be charged in NIS with the credit card.		
4,842.09			

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.



^dt33509



A Health Statement

Passport No. M8389530	Last name GEORGE	First name TRESA	Date of birth 30/06/1986	Sex Female	
Is the purpose of the trip for one or more of the travelers is to receive a medical care?				Yes	No <input checked="" type="checkbox"/>
If the answer to Question 1 is yes, we cannot accept you in the insurance.					
Section A: General Questions				Yes	No
1.	<input type="checkbox"/> Do you use, or have you been using narcotics? <input type="checkbox"/> Do you drink, or have you been drinking alcoholic beverages regularly? Please specify the quantity of consumption: glasses per day.				<input checked="" type="checkbox"/>
2.	During the last 5 years, 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).				<input checked="" type="checkbox"/>
3.	Are you now, or have you been sometime during the last 5 years, about to undergo a surgery/transplantation? Please describe in details:				<input checked="" type="checkbox"/>
4.	During the last 5 years, have you been hospitalized? Please describe in details the reason for hospitalization and the treatment that you have received.				<input checked="" type="checkbox"/>
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?				<input checked="" type="checkbox"/>
6.	Have you been diagnosed as suffering from any allergies? Please describe in details:				<input checked="" type="checkbox"/>
Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:				Yes	No
1.	<input type="checkbox"/> The nervous system <input type="checkbox"/> Cerebrovascular accident (stroke) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Muscular dystrophy or other atrophic disease <input type="checkbox"/> Reoccurring dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Balance disorders <input type="checkbox"/> Fainting <input type="checkbox"/> Parkinson's syndrome <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Trembling <input type="checkbox"/> Mental retardation <input type="checkbox"/> Autism <input type="checkbox"/> Down's syndrome <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Poliomyelitis (infantile paralysis) <input type="checkbox"/> Gaucher's disease <input type="checkbox"/> Loss of sensation (numbness) <input type="checkbox"/> Attention deficit disorders <input type="checkbox"/> Migraine <input type="checkbox"/> Have you applied to a physician with complaints regarding declined memory (dementia) <input type="checkbox"/> AIDS <input type="checkbox"/> HIV carrier <input type="checkbox"/> 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.				<input checked="" type="checkbox"/>
2.	Eyes and vision: <input type="checkbox"/> Cataract <input type="checkbox"/> Retina and cornea problems <input type="checkbox"/> Glaucoma <input type="checkbox"/> Inflammations of the eye <input type="checkbox"/> Strabismus <input type="checkbox"/> Blindness Other eye disease / problem: <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:				<input checked="" type="checkbox"/>
3.	Heart: <input type="checkbox"/> Cardiac arrhythmias <input type="checkbox"/> Heart disease <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Catheterization <input type="checkbox"/> Heart valve diseases, other heart disease / problem: <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:				<input checked="" type="checkbox"/>
4.	Blood vessels: <input type="checkbox"/> Varicose vein (in the veins of the legs) <input type="checkbox"/> Carotid artery (in the arteries of the neck) <input type="checkbox"/> Coagulation disorders <input type="checkbox"/> Blood disease DVT (Thrombosis) <input type="checkbox"/> PVD (Peripheral Vascular Disease), other vascular disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:				<input checked="" type="checkbox"/>
5.	Metabolic diseases: <input type="checkbox"/> Thyroid gland <input type="checkbox"/> Lymph node <input type="checkbox"/> Salivary gland <input type="checkbox"/> Sweat gland <input type="checkbox"/> Pituitary gland <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> High levels of fats/cholesterol, other metabolic disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:				<input checked="" type="checkbox"/>
6.	Respiratory system: <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) <input type="checkbox"/> Hay fever <input type="checkbox"/> Recurrent respiratory infections and Shortness of breath <input type="checkbox"/> Collapsed lung (Pneumothorax) <input type="checkbox"/> Cystic Fibrosis Other respiratory system disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:				<input checked="" type="checkbox"/>



^dt33509



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: <input type="checkbox"/> Ulcer (duodenum / gastric) <input type="checkbox"/> Heartburn <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Reflux <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Fissure / Fistula <input type="checkbox"/> Bowel obstruction <input type="checkbox"/> Pancreatic diseases / infections <input type="checkbox"/> Esophagus <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gall-bladder stones Other digestive system disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:		✓
8.	Liver: <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis B, C, D <input type="checkbox"/> Fatty liver <input type="checkbox"/> Cirrhosis, other digestive system disease / problem <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, when (date)? Is the problem solved? <input type="checkbox"/> No <input type="checkbox"/> Yes		✓
10.	Kidney and urinary tract: <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Kidney and urinary stones <input type="checkbox"/> Kidney cysts <input type="checkbox"/> Anomalies of urinary tract <input type="checkbox"/> Renal failure, other kidney and urinary tract disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:		✓
11.	Joints and bones: <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back / spine <input type="checkbox"/> Joints <input type="checkbox"/> Knees Other joints and bones disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:		✓
12.	Skin and sex diseases: <input type="checkbox"/> Skin tumors <input type="checkbox"/> Skin lesions <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> Syphilis Other skin and sex diseases disease / problem <input type="checkbox"/> No <input type="checkbox"/> Yes, if "Yes" please specify:		✓
13.	Malignant tumors / diseases (cancer).		✓

Date Applicant's Signature : 1/09/2021

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.



^dt33509

מספר עמוד: 4 מתוך: 6

33509

קוד מסמך

585016416621

מספר פוליסה:



Sep, 09, 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 1/10/2021 To 30/09/2022, subject to the full terms of the policy.

Name of Insured: TRESA GEORGE

Policy number: 585016416621

Passport number: M8389530

Clalit Medical Service Number: 74300444242

Sincerely,

Harel Insurance Company Ltd.



^dt33509

מספר עמוד: 5 מתוך: 6

קוד מסמך 33509

מספר פוליסה: 585016416621



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, administration 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 our website www.harel-group.co.il where you may also notify us that you are not interested in certain uses and processing of information.



^dt33509