MEUCHEDET MEDICAL INSURANCE

Dear Parents:

Yeshivat Netiv Aryeh requested that we send all their potential students literature concerning the insurance policy that will be covering your son when learning in the yeshiva. **Enrollment in this insurance is contingent upon payment of registration fees to YNA and our receipt of the enrollment and medical forms no later than July 1, 2015.**

- Covers all doctors, specialists, emergencies (excluding dental and mental health), most medications- excluding preexisting conditions
- General Doctor Visits are free- all specialists have a co-pay of about 20 shekel- per visit.
- Medications cost 15 shekel or more (generally 15) per medication.
- MEUCHEDET MAY NOT COVER YOU IF YOU HAVE HAD HEALTH ISSUES IN THE PAST - EVEN THOSE THAT ARE FULLY CURED AS OF TODAY OR IF YOU ARE CURRENTLY SUFFERING FROM ANY FORM OF CHRONIC ILLNESS- IN THIS CASE WE WILL PLACE YOU ON A SIMILAR INSURANCE PROVIDER - BUT MAY HAVE SOME DIFFERENCES IN COVERAGE AND EASE OF USE.
- This list is not a legal binding list- it is a summary of the insurance coverage we provide- see attached regulations for the complete list of rules and regulations. In case of any contradiction between the attached rules and regulations and this summery- the rules and regulations booklet takes preference.

With best wishes for a happy and healthy stay in Israel and a successful year of studies.

MEUHEDET
With all our heart :)

Provision of Medical Services for Overseas Members

Only Fill Out the Fields in the Dotted Boxes.

For internal use

Registration group

Name of organization representative

Stamp and signature of representative

1. Details of the insurance candidate

Surname	Given name	Passport / identity card no.	Date of birth	Email	● Male ○ Female
1 Hakotel Street, Jerusalem, Israel 91319				Tel	
Address in Israel	Address overseas	Workplace	ZIP	Mobile	

2. Details of spouse / partner

[redacted]

3. Details of family members

[redacted]

Relation	Surname	Given name	Passport / identity card no.	Date of birth	Male / Female
	Surname	Given name	Passport / identity card no.	Date of birth	○ Female
	Surname	Given name	Passport / identity card no.	Date of birth	○ Female
	Surname	Given name	Passport / identity card no.	Date of birth	○ Female
[redacted]					

4. Requested coverage type

● Enrolment for basic level ○ Enrolment for additional plans

[redacted]

	Preferred	Premium
Name of candidate-		
Name of candidate		
[redacted]		

Start date of the insurance will be the first day of the month after approval of the admission to the program by the organiazion or approval of the terms determined by the organization if you have been requested to approve them, whichever is later.

5. Declaration of the insurance candidate

This declaration relates to each of the insurance candidates listed in this proposal form.
I hereby request to enroll in a prgram for healthcare services for overseas members and/or additional healthcare services, with Meuhedet Healthcare Organization (hereinafter: the Plan) as specified above (relying on all the statements provided in this proposal).
For your attention, the Plan will take effect subject to your signing the full health declaration, on the condition that approval of your admission to the Plan is received from the organization. Your answer and/or the information given to the insurer will be stored in a database in accordance with the provisions of recevied from the organuzation. Your answer and/or the information given to the insurer will be stored in a database in accordance with the provisions of the Privacy Protection Law 5751-1981, and will be used for insurance purposes only.

A. I declare, agree and warrant hereby that:

1. All the answers as provided in the proposal and health declaration are correct and full and have been given out of my free will.
2. The answers provided in the proposal and in the health declaration and any other information that is given by me to Meuhedet Healthcare Organization (hereinafter: the Organization) and the standard terms of the Organization for this purpose, will serve as a basic condition to the contract between us and will constitute an intqral patr thereof.
3. I / we are aware that my rights in the Plan will take effect after the Organization issues written approval of admission of the candidate to the Plan, and on the condition that the first premium has been fully paid.
4. I am aware that membership fees are collected by Meuhedet Healthcare Organization. In the future, membership fees may also be collected by another corporation on behalf of the Organization, and I shall have no claims as to the identity of the corporation performing the collaction.

B. For your attention: This Plan has limitation concerning pre-existing medical condition. **Please read the regulation of the Plan carefully.** The binding text of the regulation is the Hebrew version.

doctor Even the it up (e.x. 16)!

6. Declaration of health

Name_____

I, the undersigned, do hereby request from "the Meuhedet Healthcare Organization" to insure me in accordance with all that is stated hereinafter. Please answer the following question and indicate "Yes" or "No". If the answer to one or more of the question is "Yes", you must state the number of the question, and give full details, enclose medical documents and indicate the name of the family member for whom the answer is positive.

Question Have you had one or more of the following disorders:	Answer	Name of the insured referred to in answer	Year of event	Details of answers (please attach documents)
1. Chronic renal (Kidney) failure	○Yes○ No			
2. Gaucher disease	○Yes○ No			
3. Thalassemia major / intermedia	○Yes○No			
4. Hemophilia	○Yes○ No			
5. HIV Carrier / AIDS	○Yes○ No			
6. Oncological disease / cancer	○Yes○ No			
7. Cystic fibrosis / CF	○Yes○ No			
8. Tuberculosis	○Yes○ No			
9. Have you been injured in a work accident	○Yes○No			
Read Carefully 10. Have you been injured in a trafic accident	○Yes○No			
11. **Are you able to perform without the assistance of others and without any restriction all the following daily activies:** A. Walking B. Dressing C. Washing D. Eating and drinking E. Controlling your sphincters (continence)?	○Yes○No			
12. Do you have or have you had a congenital defect, genetic (hereditary) disease or temporary or permanent disability?	○Yes○No			
13. Have you had one or more of the following disorders: A. Stroke (CVA) B. Diabetes C. Dementia / Alzheimer's / mantal debilitation D. Heart disease or heart failure E. Malignant disease F. Chronic liver disease G. Amputation of organs / weakness or paralysis of limbs H. Chronic Degenerative disease of the nervous system and muscles (ALS, MS, Parkinson's) I. Hypertension J. High blood lipid values (cholesterol and triglycerides) K. Excessive blood clotting conditions L. Mental disease M. Blindness N. Chronic lung disease (COPD) O. Skeletal and articular diseases P. Other chronic diseases 14. Have you previously been hospitalized for more then 6 days (other than childbirth)? Attach documents and current information.	○Yes○No			
15. Have you had surgery in the last 12 months, or are you aware of the need to have surgery, substantial medical treatment or hospitalization?	○Yes○ No			
16. Have you had special examinations in the last 6 years? Such as MRI, CT?	○Yes○ No			
17. Have you taken / are you taking medications on a regular basis? Which medications?	○Yes○ No			
18. Do you consume narcotics or alcohol?	○Yes○ No			
19. Have you had / are you having medical / developmental / psychological / psychiatric follow-up?	○Yes○No			
20. Have you received special services for care at home?	○Yes○No			
21. Do you smoke / have you smoked in the last year?	○Yes○No			
22. Are you receiving a disability allowance / live-in nursing care of any kind?	○Yes○No			

7. Do you have medical insurance in Israel / abroad?

○Yes ○No | Name of company | Name of program | Term of insurance

8. Waiver of medical confidentiality (for the purpose of claiming admission conditions or inquiring on claim)

I, the undersigned, hereby give permission to all the physicians, medical institutes and other hospitals in Israel and abroad and the National Insurance Insitute and/or any organization or other body (hereinafter: "the Medical organizations") and/or other insurance companies to give the Mehuedet Healthcare Organization all details, without exception, in the form required thereby as elaborated in documents in the possession of the medical institutes, for the purpose of inquiry by Meuhedet Helthcare Organization according to the Plan, and I hereby relieve the aforesaid medical institutes of the duty to safeguard medical confidentiality and waive this confidentiality towards the Mehuedet Healthcare Organization. This waiver binds me and will also apply to my children who are minors and legal agents. This waiver binds me and will bind my heirs and estate after my death.

9. In witness whereof, we have put our hands hereunto

Sign Here

Date	Name of candidate	Signature of candidate
Date	Name of candidate	Signature of candidate