PassportCard Insurance Application Form - Academic Students

Dear Applicant,

We will be happy to assist you with any question that may arise while filling in this form.
You can find our toll free numbers online at https://www.passportcard.co.il/contact/
This application form is valid for 30 days from the date of signature. You are kindly requested to fill this form in its entirety. For children over the age of 18, a separate application should be completed.
If you are covered by another insurance plan, we recommend that you do not cancel it until we officially approve your acceptance. Please note that you can view the policy on the self service website and App.

Please make sure to carefully read the declarations in section 8 of this form.

Date:

1 | General Details

The medical insurance required for the Country of Destination:

Business customer Company name

Name and title of contact person

Requested insurance start date dd mm yy (Please note that the insurance will be vaild only after a written approval is recieved from the insurer).

2 | Personal Details

Primary Applicant Details

Last name First name Gender F / M

Date of birth dd mm yy Country of birth Citizenship

Local ID No. Passport No. Additional citizenship

Secondary Applicant Details

Last name First name Gender F / M

Date of birth dd mm yy Country of birth Citizenship

Local ID No. Passport No. Additional citizenship

Dependent under 18's Details: First child

Last name First name Gender F / M

Date of birth dd mm yy Country of birth Citizenship

Local ID No. Passport No. Additional citizenship

Dependent under 18's Details: Second child

Last name First name Gender F / M

Date of birth dd mm yy Country of birth Citizenship

Local ID No. Passport No. Additional citizenship

Dependent under 18's Details: Third child

Last name First name Gender F / M

Date of birth dd mm yy Country of birth Citizenship

Local ID No. Passport No. Additional citizenship

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3 | Address

Name of Addressee | Street & House No. | City

Zip Code | Home Phone No. | Mobile Phone

E-mail

4 | Details of contact person (proxy) authorized to receive documents (including the policy) and to sign in your name

Last name | First name

Street & House No. | City

Zip code | Home Phone No. | Mobile Phone

E-mail

5 | Medical Questionnaire

This medical questionnaire will determine the terms of your acceptance or non-acceptance to the insurance.

Please read very carefully the questions and mark your answer in the appropriate column. Your attention is required concerning the following details:

A. The following medical questionnaire enables our company to perform a correct risk evaluation concerning acceptance to the medical insurance. Please remember that partial or incomplete answers have implications that may affect your entitlement for coverage, according to the Law of Insurance Contract (1981) and the regulations of the insurance comptroller concerning previous medical status.

B. Every applicant for insurance over the age of 18 must answer the questionnaire.

C. For applicants under 18, the primary applicant must answer. If the primary applicant and the other applicants are under 18, the legal guardian of the applicants will answer and sign in the relevant places. Please make sure that the guardian's details have been completed in accordance to clause 4 of this form.

D. Any positive answer in the questionnaire requires a detailed description in clause 6. It is possible and also recommended to attach any medical or other documentation that relates to the answers of the questionnaire.

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BMI	Primary Applicant		Secondary Applicant		1st Child (under 18)		2nd Child (under 18)		3rd Child (under 18)	
	Weight	Height	Weight	Height	Weight	Height	Weight	Height	Weight	Height
Weight in kg. / Height in cm.										

QUESTIONS	Primary Applicant		Secondary Applicant		1st Child (under 18)		2nd Child (under 18)		3rd Child (under 18)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
01. Do you currently smoke or did you smoke in the past or take any recreational drugs, or suffer from alcoholism, or consume alcoholic beverages?										
02. Are you pregnant? Have you had complications during pregnancy or birth, Cesarean sections, abortions, or miscarriages?										
03. Have you been in the past 10 years involved in any accident or incident, including a road accident, that resulted in injury or loss of function?										
04. Do you currently or have ever suffered from, been treated for, or diagnosed with disorders of the respiratory system, including lung diseases and/or respiratory airways (such as asthma, Deviation of nasal septum, sinusitis) and/or sleep apnea?										
05. Do you currently or have you ever suffered from, been treated for,or diagnosed with disorders or diseases of the digestive system (esophagus, stomach, intestines, anus), anorexia or bulimia?										
06. Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders or diseases of the urinary tract or kidneys?										
07. Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders and diseases of the eyes, ears (including recurring ear infections), nose, sinuses, jaw, pharynx ,throat, or teeth/gums?										
08. Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders and diseases of the skeleton, back and/or spinal column, muscle system, limbs, or joint tissue?										
09. Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders and diseases of the skin (such as psoriasis, multiple skin marks, warts, acne or pimples)?										
10. Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders and diseases of the liver (including hepatitis\fatty liver), gallbladder, appendix, spleen, or pancreas?										
11. Do you currently or have you ever suffered from, been treated for,or diagnosed with disorders and diseases of the heart or had a stroke (CVA or TIA)?										
12. Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders and diseases of the blood vessels, abnormal blood tests, high\low blood pressure (hypertension or hypotension) , excess lipids in the blood (high cholesterol), abnormal blood count, or any form of clotting problems?										
13. Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders and diseases of the nerve system, brain disorders, or epilepsy?										
14. Do you currently or have you ever suffered from, been treated for, or diagnosed with long-term headaches, dizziness, migraines, head contusions, or loss of consciousness?										
15 Do you currently or have you ever suffered from, been treated for, or diagnosed with disorders and diseases of the immune system, including HIV, or infectious diseases?										
16. Do you currently or have you ever suffered from, been treated for, or diagnosed with any type of allergies?										
17. Do you currently or have you ever suffered from, been treated for, or diagnosed with hormonal or metabolic disorders, including disorders of the thyroid gland, or diabetes (sugar in the blood or in the urine)?										

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QUESTIONS	Primary Applicant		Secondary Applicant		1st Child (under 18)		2nd Child (under 18)		3rd Child (under 18)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
18. Do you currently or have you ever suffered from, been treated for, or diagnosed with malignant or benign tumor, cyst, polyp, lump, and\or cancer or precancer?										
19. Do you currently or have you ever suffered from, been treated for, or diagnosed with paralysis or any form of disability?										
20. Do you currently or have you ever suffered from, been treated for, or diagnosed with: (for a candidate whose innate gender is male) disorders of the prostate, testicles, or venereal disease? (for a candidate whose innate gender is female) diseases of the female reproductive system, including venereal diseases, or abnormal conditions in the breasts?										
21. Do you currently or have you ever suffered from, been treated for, or diagnosed with hernia?										
22. Do you currently or have you ever suffered from, been treated for, or diagnosed with congenital disorders/diseases and/or any hereditary diseases?										
23. Do you currently or have you ever suffered from, been treated for, or diagnosed with cognitive disorders and/or mental health disorders, attention and concentration deficit disorders, autism and\or psychological\psychiatric treatment?										
24. Do you currently or have you ever, taken medications on a regularbasis for a treatment of any medical condition (for a continuous period of more than 60 days)?										
25. Were you hospitalized in the past, or were you candidate for surgery, have you undergone surgery, or are you currently candidate for surgery or hospitalization?										
26. Have you had signs, symptoms, diagnosis, treatment or negative results of medical tests that you have not specified in this questionnaire?										
27. Do you usually perform routine check-ups for early diagnosis or prevention of diseases such as: blood tests, echocardiography (cardiac echo), skin, or gynecological examination etc.?										
28. Do you have additional medical insurance, or were you ever been denied or accepted under special condition(s) for health or life insurance?										
29. To the best of your knowledge, do you have any relatives (parents, brothers, sisters, or children) who suffer or suffered from heart or blood vessel diseases, cancer, high cholesterol, chronic mental disorders, or any hereditary disease?										

Full Name of Primary Applicant _____ Signature _____

Full Name of Secondary Applicant _____ Signature _____

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6 | Detailed Medical History

Please describe in detail (according to the questions you answered positively in the questionnaire) the current status of the condition, dates of medical treatment, diagnosis, prognosis, course of treatment, and the primary care physician's contact details.

Question No. ___ ___ Name of the Family Member _____

Question No. ___ ___ Name of the Family Member _____

Question No. ___ ___ Name of the Family Member _____

Question No. ___ ___ Name of the Family Member _____

* Additional information may be required

** An additional page, for more detailed descriptions may be attached to the form if necessary.

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7A | Applicants' Declaration

I, the undersigned, request on behalf of myself and my family members to be insured according to this declaration. I declare that all my answers are as detailed in the offer, and in my and my family members' health declarations, are complete and accurate.
I understand that my answers will serve as a basis for the requested insurance contract and will be an integral part of it. I understand that answers that are not complete and/or correct and failure to disclose substantial details in connection with the offer and the health declaration, may lead to the cancellation of the policy, non-payment of claims, and the taking of other measures stipulated by law.
Pre-existing medical condition: I declare that I know, and I agree that it is my duty to declare any medical condition that existed before I was accepted for insurance, or which is now taking place. I understand that a previous medical condition that existed before I was accepted for insurance and was not declared, may result in the cancellation of the insurance contract and rejection of future claims.
Medical underwriting and insurance acceptance conditions: The insurance contract will only be issued if the offer is approved by the company. I understand that my health declaration and that of my family members, will undergo medical underwriting and that the insurance company may decide on acceptance conditions that reflect the additional insurance risk arising from the health declaration, including limitations in coverage and/or additions to premium or denials.
Supervising Authority: I understand that the policy is under the supervision of the State of Israel - the Ministry of Finance - the Capital Market Authority - the Insurance Commission.
Insurer: The insuring company is David Shield Insurance Company Ltd.
Communications: I understand, and I agree that communications and mail will be sent as needed to my address country of origin address and/or to my address abroad and/or to the email address and/or to the personal area of the company website. I also know and I agree that the policy, registered letters, and documents will be sent to my country of origin address, and its arrival at my countty of origin address will constitute legal delivery.
Jurisdiction and applicable law: I am aware that the policy is an Israeli policy, subject to Israeli law and Israeli jurisdiction only, regardless of whether it was executed by telephone and/or mail and/or otherwise, and was carried out in the State of Israel. The place of jurisdiction is a qualified court in Israel.
Other citizenship: I understand that if I and/or any of the applicants for insurance in this offer hold American citizenship or have similar rights in the USA or citizenship, the country where we are residing or are planning to reside, we understand and agree that the PassportCard policy is an Israeli policy for receiving services worldwide, and therefore I am and will be subject to various conditions and limitations according to the laws of the country where I will be residing.
The policy wording: I understand, and I agree that for the purpose of clarifying all matters concerning this insurance, the prevailing wording is the policy only.
Service providers: I understand and agree that my details and the details of my family members insured with me will be transferred to medical providers in my country of origin and/or abroad on behalf of the insurer and/or Davidshield, for the purposes of receiving the services in accordance with the instructions of the policy and will keep them in the databases of the insurer and/or someone on its behalf for these purposes.

7B | Doctor's Room-Declaration

I hereby declare that I am aware and consent to the fact that: The Doctors' Room is operated by senior physicians who provide assistance and advice on medical matters to the best of their knowledge and on the basis of their professional experience.
The advice given by the Doctors' Room is based solely on medical considerations and medical ethics. I must clarify whether the insurance policy that I hold includes coverage of the recommendations given.
The advice that will be given is essentially limited as it is not accompanied by a physical examination, and is based on a subjective description of the medical problem as I have presented it.
In view of the aforesaid, I am aware that the service does not in any way represent an instruction for treatment nor it is a substituted for examination by a physician. I will relate to the service as background material only.

By signing this application form I hereby approve DavidShield Life Insurance Agency (2000) Ltd.'s privacy statement as it appears on the company's website.
Signatures are required for sections 7A and 7B

Date	Passport No.	Name	Signature
Date	Passport No.	Name	Signature
Children under 18			
Full Name of Preparer			

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7C | Medical Confidentiality Waiver

By signing the "Medical Confidentiality Waiver", you forego your rights and the rights of the other persons insured under this policy for protecting the confidentiality of medical information.
We will use this waiver only in matters regarding an inquiry about your liabilities and entitlements, or those of other persons insured under this policy, as may be required.
Please note, every applicant over the age of 18 must confirm the statement with his signature.
By your undersigning, you authorize, your primary care physician or the physician of your family members insured with you, or any other physician and/or any other medical institution in which you or your family members were or are treated to transfer to "DavidShield, Insurance Company Ltd." and/or "DavidShield Insurance Agency Ltd." or to their representative (hereafter "the requesting party") all the data with no exception and in the manner requested by the Requesting Party and/or its representatives, concerning the medical status, existing or past diseases, as well as any finding or diagnosis in their possession that are related to the medical situation or the medical situation of other the persons insured under this policy, all of this on condition that the information is necessary for determining entitlements and liabilities according to the policy.
By undersigning you release any entity or person as detailed above from the obligation of medical confidentiality and you will have no argument or claim of any kind and type to whoever provides the information as mentioned.
This waiver applies to the undersigned, their estate, their legal representatives and whoever replaces them.

With your signature below you declare and acknowledge that DavidShield will provide you with a self-service website and application that enables you to view the policy details and the details of the insured members under the policy, including the secondary applicant and children, as well as to carry out actions such as updating personal information and filing insurance claims.

Primary Applicant's Statement:

I allow the secondary applicant to view personal information and perform actions on the website and application: Yes ☐ No ☐

Secondary Applicant's Statement:

I allow the primary applicant to view personal information and perform actions on the website and application: Yes ☐ No ☐

Please specify parent (or legal guardian) information in order to view children under the age of 18 and perform actions on the self-service website and application:

Full name: _____

* If you are not adding children under the age of 18 to the policy, ignore this section.

Applicants' Signature(s)

Full Name of Primary Applicant _____ Signature _____ Date _____

Full Name of Secondary Applicant _____ Signature _____ Date _____

Children under 18 _____ Name of person who completed this form _____

* Requires the signature of the primary applicant and the secondary applicant.

Full Name of Preparer _____

Thank you for completing PassportCard insurance application.

Please make sure that: the details you provided in section 1-7 are complete and correct, and that you read and signed the declarations stated in section 7 of this form.

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8 | Request for Payment

The undersigned hereby issues an ins truction for the benefit of "Phoenix insurance company Ltd." to charge the credit card the details of which are listed below for the insurance premiums according to the policy and its appendices.

Type of card: ☐ mastercard ☐ Diners ☐ Visa ☐ American express

Name of card owner _____ Expiration date mm yy

card No. _____

Primary Policy holders name _____ Number on back of card _____

Card holder's signature _____ ID or passport _____

*Only USD

Full Name of Preparer _____

Thank you for completing PassportCard insurance application

Please make sure that:

The details you provided in section 1-9 are complete and correct, you read and signed the declarations stated in section 8 of this form.

Please send this form to: **joinrelo@passportcard.com**

For agent's use only

Agent name _____ Phoenix company ☐ other _____ agent No. _____

Phone No. _____ Cellphone _____

Address _____

Supervisor No. _____ supervisor name _____ agency name _____

I, the undersigned, the insurance agent mediating between the policy holder and applicants and the company, hereby declare, that I have asked the applicants for insurance and/or the policy owner all the aforementioned questions, including the credit card number or the standing instruction and the answers are as were given me personally.

Agent signature _____

9 | Duty of Disclosure according to paragraph 6-8 of the Insurance law (1981)

6. (a) Where before the conclusion of the contract the Insurer asks the Insured in writing, either on the insurance proposal form or otherwise, a question as to a point likely to affect the willingness of a reasonable Insurer to conclude the contract at all or to conclude it on the conditions contained in it (hereinafter: 'material matter'), the Insured will reply to it in writing completely and straightforwardly.
(b) A sweeping question, embracing various matters without differentiating between them, requires no reply as aforesaid unless it is reasonable at the time of the conclusion of the contract.
(c) The concealment by the Insured, with fraudulent intent, of something he knows to be a material matter will be treated as the giving of a reply which is not complete and straightforward.

7. (a) Where a reply which is not complete and straightforward is given to a question concerning a material matter, the Insurer may, within thirty days from the day on which he becomes aware of this and so long as the event Insured against has not occurred, cancel the contract by written notice to the Insured.
(b) Where the Insurer cancels the contract by virtue of this section, the Insured is entitled to a refund of the insurance premium paid by him for the period subsequent to the cancellation, less the expenses of the Insurer, unless he acted with fraudulent intent.
(c) Where the event Insured against occurs before the insurance contract is canceled by virtue of this section, the Insurer is only liable to such part of the insurance benefits as bears to the whole thereof the same proportion as the agreed insurance premium bear to the premium which, according to his usual practice, would have been paid on the basis of the true situation; and he is altogether discharged from liability if any of the following is the case:
(I) the reply was given with fraudulent intent;
(2) a reasonable Insurer would not have entered into the contract, even for higher premium, had he known the true situation; in this case, the Insured is entitled to a refund of the premium paid by him for the period subsequent to the occurrence of the event Insured against, less the expenses of the Insurer.

8. In any of the following cases, the Insurer is not entitled to the remedies mentioned in section 7 unless the reply which was not complete and straightforward was given with fraudulent intent:
(1) he knew or should have known the true situation at the time of the conclusion of the contract or he caused the reply not to be complete and straightforward;
(2) The fact in respect of which a reply which was not complete and honest was given ceased to exist before the occurrence of the event Insured against or did not affect its occurrence or the liability of the Insurer or the extent thereof..