Maccabi Members Frail Care Insurance

Maccabi Frail Care
New from the Phoenix

Customer Relations Center, Tel: 1-801-22-7788 or *3507
Head Office: 53 Hashalom Way, Givatayim 5345433
www.fnx.co.il | sm@fnx.co.il

Sign up Form for the Group Frail Care Insurance for members of Maccabi Health Services Through the Phoenix Insurance Company Ltd.

"Fund Transferor" – was there frail care insurance at the previous Health Care Fund ○ Yes ○ No

- The terms for obtaining frail care insurance are subject to filling out a health declaration, medical underwriting and authorization from the insurer (with the exception of infants under 1 year in age).
- The commencement of the insurance will be as of the date that all the items required on the form have been filled in.

Part 1 – Personal and Family Details

➢ **Details of the Candidates for the Insurance (Children – under the age of 18)**

	I. D. No.	Surname	First Name	Date of Birth	Gender
Main Candidate	| | | | | | | | |			| | | | | |	○ M ○ F
Spouse	| | | | | | | | |			| | | | | |	○ M ○ F
Child 1	| | | | | | | | |			| | | | | |	○ M ○ F
Child 2	| | | | | | | | |			| | | | | |	○ M ○ F
Child 3	| | | | | | | | |			| | | | | |	○ M ○ F
Child 4	| | | | | | | | |			| | | | | |	○ M ○ F

The insurance cover is not valid for an insurance incident which occurred during the first three years of the life of the insured.

➢ **Contact details and consent to receive report documents via the contact details**

For your information, the up to date details are the details submitted to Maccabi. Insofar as you did not submit contact details to Maccabi, these are to be filled in on the form. To change / update the details, contact the Maccabi hot line on *3555.
Fill in contact details with respect to the candidate for adult insurance (over 18 years of age) and to choose the manner of receipt of the report documents (full disclosure, insurance details sheet and annual report) from the Phoenix Insurance Company Ltd.
Insofar as you will not choose the preferential manner to receive report documents, the documents will be dispatched according to the existing contact details, pursuant to the directives of Circular No. 1-1-2018 in this matter (should an email address exist – the report documents will be dispatched to the email address. In the absence of an email address – the report documents will be dispatched to the mobile telephone number receiving the SMS. In the absence of a mobile telephone number – the report documents will be dispatched by snail mail).
In the absence of contact details for candidates for adult insurance, the Phoenix will deem the contact details of the main candidate / policy holder as being the contact details of all the adult candidates for insurance in the policy.
A change in the manner of receipt of the stated report documents will be effected by means of the Customer Service Hotline on *3507.

	Snail Mail Postal Address – Obligatory to be filled in) (Fill in only if the details are not up to date at Maccabi)				Mobile Tel.	Email	Manner of Receipt of Report Documents (Mark One) A SMS will be dispatched for each of the options
	Street	Bldg. No.	Town	Zip Code			
First Candidate							○ Email ○ Snail Mail
Spouse							○ Email ○ Snail Mail

Part 2 – Health Declaration

In any case of the candidate being over 65 years of age, a summation medical record from the treating doctor is to be produced.

General Questions ** All the questions are referred to the candidate for insurance and / or the parent and / or the guardian of the candidate for the insurance who is a minor or a legally incompetent person			Main Candidate			Spouse			First Child			Second Child			Third Child			Fourth Child		
			Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known
1	Height (in cm.)		O																	
	Weight (in kg.)																			
2	a. Do you smoke or did you smoke in the past?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
		Quantity per day:	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
		Number of years	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
	b. If you have stopped smoking state, in addition, when you stopped																			
		Quantity per day:	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
		Number of years	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
		Date stopped smoking	___ / ___ / ___			___ / ___ / ___			___ / ___ / ___			___ / ___ / ___			___ / ___ / ___			__ / ___ / ___		
3	Are you partially or fully restricted in independently carrying out one or more of the following actions: Walking, standing up and sitting down, dressing, bathing, eating and drinking, control of sphincters (stool and urine)		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
Was any of the candidates for insurance diagnosed with one of more of the deformities / diseases / situations / finding detailed below? (for every positive response, the response is to be detailed and / or a doctor's letter be attached.																				
4	Vasculitis (blood vessel inflammation, PAN)		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
5	5.1	Insofar as you responded "yes" to the previous question, do you take Insulin? (Details required: What are the HbA1c hemoglobin values?)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
		6.5 or less	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
		6.6 - 7.5	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
		7.6 - 8.5	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
		8.6 - 9.5	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
		9.6 and over	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	5.2	Is there any damage to target organs (neuropathy, retinopathy, PVD – peripheral vascular disease)?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	5.3	Were there appearances of hypoglycemia?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
6	Endocrinology diseases – do you suffer from one or more of the following Endocrinology diseases: Hyper or hypo Thyroid gland activity, adrenalin, hypophesis, hypothalamus?			O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	6.1	Do you suffer from other Endocrinology diseases?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	6.2	In the event that your response was yes – are you balanced over the past year?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
7	Nervous and Brain system – Do suffer from one of more of the following neurological diseases? Including a stroke (CVA, TIA), retardation, Parkinson's disease, ALS, MS, polio, weakness or paralysis of limbs, myasthenia, epilepsy, peripheral nerve damage (limbs or face)			O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	7.1	Have you suffered a stroke (CVA) over the past 2 years (24 months)?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	7.2	Have you suffered a stroke (TIA) over the past 2 years (24 months)?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	7.3	Was there any damage to the spinal cord that caused paralysis, hemiplegia, - left or right side paralysis, paraplegia, - upper or lower body paralysis, Tetraplegia – paralysis of 4 limbs?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	7.4	Was there peripheral nerve damage?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	7.5	Have you suffered an attack of epilepsy?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	7.6	Did to consult a doctor with complaints related to a degradation in memory over the past 3 years?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	7.7	Are you receiving treatment to improve cognoscente (memory) situations?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

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			Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known
8	Cardiac and blood vessel diseases		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	8.1	Do you have a transplanted heart?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	8.2	Do you suffer from heart failure? (angina factoris, etc.) or from atrial fibrillation?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	8.3	Have you undergone open heart surgery – bypass or valve replacement?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	8.4	Insofar as you responded “Yes” to the previous question, have you undergone open heart surgery – bypass or valve replacement during the past year?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	8.5	Have you undergone cardiac catheterization: Valve replacement (TAVI) general artery surgery, electrophysiology (EPS) treatments over the past year?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
9		Malignant oncological disease (Cancer)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
10	Do you suffer from one or more of the following diseases: Chronic liver disease (cirrhosis, fibrosis) chronic pancreas inflammation; liver or pancreas transplant?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	10.1	Do you suffer from any other chronic liver disease?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	10.2	Do you suffer from hepatitis?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
11	Do you suffer from chronic inflammation of the digestive system (Chrone’s disease colitis, acute colitis?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	11.1	Has more than 3 years passed since the last attack?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
12	Do you suffer from a birth defect, retardation, CP, immune failure, hyperlipidemia against a family / hereditary background?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	12.1	Do you suffer from any other birth defect?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	12.2	Were you or are you under the care of a developmental medicine?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
13	Amputations – is there an effect on daily functioning?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
14	Have you suffered from hypertension over the past 10 years? (Details required: when was the diagnosis date? What are the systolic values: 40 - 250; What are the diastolic values: 40 - 150)?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
15	Have you suffered from hyperlipidemia over the past 10 years? (Details required: General blood cholesterol level 70-400; Blood HDL 0 - 200). Fill in the values in the table below.		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
16	Have you been diagnosed as suffering from mental problems?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
17	Chronic lung disease – Are you a lung transplant or suffer from COPD, cystic fibrosis, chronic bronchitis, emphazema.		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	17.1	DO you suffer from other lung diseases?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	17.2	Do you suffer from Asthma with a number of attacks or hospitalizations per month?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
18	Storage diseases (Gaucher, Hydrogen-Pike, Tysex, Fabry, Pompe, Cystic Fibrosis)		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
19	Kidney diseases or urinary tract ingfections		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	19.1	Do you or have you undergone dialysis treatments? Do you have a transplanted kidney?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	19.2	Do you suffer from kidney failure and / or from a polycystic kidney?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
20	Problems with blood clotting (hemophilia, telesemia or other blood clotting problems?)		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
21	AIDS HIV?		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
22	Muscle and skeletal diseases (chronic back pain, osteoporosis, artitis, other muscle and skeletal diseases?)		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
23	Do you suffer from Rheumatoid diseases (lupus, rheumatoid arthritis, Scleroderma, psoriatic arthritis, temporal arthritis, Polyimagny and Rheumatica?)		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
24	Fibromyalgea		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
25	Were you hospitalized over the past 5 years or do you hold a recommendation for hospitalization? (Details required: When was the hospitalization, the reasons for the hospitalization, the duration of the hospitalization?)		O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

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		Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known	Yes	No	Not Known
26	Have you undergone surgery over the past 12 months or are you aware of the need to undergo surgery, or medical procedure involving hospitalization or operating theatre procedure? (Details required: When was the surgery, the reasons for the surgery, the name of the surgery, the results of the surgery at this point in time, are you under observation?)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
27	Have you undergone an imaging test over the past 5 years? Or you have been recommended to undergo such tests over the past 6 months (MRI, CT, PET CT, bone density mapping)? (Details required: When did the test take place, the type of test, are you under observation?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
28	Have you taken or do you take regular medications over the past 5 years? (Please detail the medications and when).	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
29	Do you consume more than 5 cans of beer per day or more than 5 glasses of an alcoholic beverage per day?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
30	Have you received special services for home treatment over the past 5 years? (Details required as to which year, what was the reason and by whom?)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
31	Have you applied in the past to sign up for frail care insurance and were rejected? (Details required: At which company and what was the reason for the rejection?)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
32	Do you currently receive or have you received, over the past 5 years, a frail care pension or disability pension from the National Insurance Institute?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

If you response to one of the questions was “Yes”, please detail the positive findings in the table below.

➢ **Details of the Positive Findings**

Name of the Candidate	Question No.	Diagnosis / Disease / Test	The commencement / end date, complications Yes / No, Recurring events Yes / No, Full Recovery Yes / No.	Type of treatment (Medication, surgery. Etc.)

➢ **Insurance Fees Table ***

Age Group	0-18	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	Over 81
Premium	---	7.19	8.7	26.51	35.81	40.43	78.61	95.93	111.13	131.78	163.7	190.24	205.85	213.88

* The premium amounts are linked to the base Consumer Price Index which was known as at July 1, 2017

➢ **Insurance Benefits ****

Place of Sojourn of the Insured	First Sign Up Age for Group Frail Care Insurance for Health care Fund Members		
	Up to Age 49	50 to 59	60 and over
Monthly insurance benefit for an insured sojourning at home (compensation)	NIS 5,500	NIS 4,500	NIS 3,500
Monthly insurance benefit for an insured sojourning in an institute (compensation)	NIS 10,000	NIS 6,500	NIS 4,500

** Linkage discrepancies and interest will be added to the insurance benefit amount, based on the Consumer Price Index known on June 15, 2016.

➢ **Medical confidentiality waiver and insurance candidate declaration:**

1 I hereby declare my absolute and irrevocable consent to waive medical and / or functional confidentiality and authorize the insurance company to request, to receive information about my health and / or functions in the past, present and future, to the extent necessary for the purpose of clarifying the rights and obligations granted under the policy. I hereby waive this confidentiality towards the insurance company and I shall not have any claim or claim of any kind in connection with the receipt of such information with the institution providing the information and / or its employees.

2 I also agree in advance that any institution, including Maccabi Health Services and / or the Maccabi Magen Association or its medical and / or other employees, who have medical and / or functional information and / or social and / or nursing and / or rehabilitative conditions and / or any disease that I have experienced in the past or that I am currently suffering from as a result of this illness, will be disclosed to the insurance company at its behest I shall have no claim or claim against the provider of the information. I hereby release any institution and / or its employees from the duty to maintain confidentiality in all matters relating to health and / or rehabilitation and / or social services and / or nursing care and hereby allows them to provide any information to the insurance company from any file that was opened in my name. My request is also pertinent under the Protection of Privacy Law 5741 - 1981 and also according to the Patients' Rights Law, 5756 - 1996, and applies to all other medical information found in the database of each institution.

3 This disclaimer obligates me, my estate and my legal representatives and anyone who will replace me.

4 I hereby declare that the information contained in this Declaration is given voluntarily and with my full consent and that it has been brought to my attention and I agree that the information I have provided and / or any information that will come to the possession of the insurance company and / or Maccabi Health Services and / or Maccabi Magen will be held in databases in Maccabi Health Services and / or Maccabi Magen and / or the insurance company and / or any entity acting on their behalf, and that the information collected as aforesaid shall be used by the insurance company and / or Maccabi Health Services and / or Magen Magen and / or any entity acting on their behalf. The information collected as aforesaid shall be used by the insurance company and / or by any entity acting on its behalf for the purpose of examining the application, managing the policy, providing services within the framework of the policy and meeting the requirements of the law. The information collected will be used by Maccabi Healthcare Services for the purpose of managing the policy, provision of collection services within the framework of the policy and compliance with legal requirements.

5 I request that if my proposal to join the insurance in question will be accepted, the insurance premiums required under the terms of the policy, will be collected by means of the stop order that I submitted to "Maccabi Health Services" for the purpose of payment for medical services and insurance. If Maccabi Health Services does not have a valid stop order as stated, the insurance in question will not take effect until the arrangement of a valid standing order is effected.

6 I undertake to report to the insurance company about any change that will apply to my medical condition from the date of fulfillment of the Health Declaration until the date of the Insurer's consent to approve my acceptance for insurance. I am aware of the fact that if I do not report the change, my rights under the policy may be affected.

7 I, the undersigned, hereby declare that all the particulars provided on the sign up form and the attached documents are true and complete, and that I am aware that the answer to the question that was not complete and honest may affect my rights by virtue of the policy, including my entitlement to receive insurance compensation in whole or in part.

8 If you are a person with disabilities, as defined in the Equal Rights for People with Disabilities Law, 5758 - 1998: "A person with a physical, mental or intellectual disability, including cognitive impairment, permanent or temporary, for which its function is substantially limited in one or more of the main areas of life", please update us by telephone 1-801-22-7788, in order for your application to receive insurance will be examined in accordance with the law.

			X
Name of the Main Candidate	I. D. No.	Date	Signature
			X
Spouse	I. D. No.	Date	Signature

** The signature of a guardian for children under the age of 18, and for whom an I. S. No., date and signature was filled in on the declaration.

➢ **Non Consent for an Internet Interface to Detect Insurance Products:**

The Capital Markets and Savings Authority runs a secure website that enables you to view, in a summated form, your insurance products at all the insurance companies in Israel, and this is based on the data that we will submit to the them. In the event that you do not want use to submit the details, please mark an X

O Main Candidate O Spouse O First Child O Second Child O Third Child O Fourth Child

For your information, the non - transfer of data will prevent you from viewing your insurance products from all the insurance companies in Israel in summation form at the secure website

You can change your decision at any time at the website of the company at the following URL: www.fnx.co.il or by telephone: (074) 731-1155