WELL COME Healthcare Services

Maccabi The Best Healthcare Group in Israel

Well-Come Plan Application

(This plan is intended for those not covered by the National Health Insurance Law*)

Section A – Requested Service

I hereby request to join the Well-Come plan and receive medical services from Maccabi Healthcare Services, as I am not covered by the National Health Insurance Law 1994.

Magen Zahav	Maccabi Sheli	Nursing Care Zahav	Keren Maccabi

(Tick ✓ the relevant box.)

☐ I am not a resident of the State of Israel.
☐ I am subject to a waiting period according to section 58 of the National Health Insurance Law.
☐ My previous membership application was denied.
☐ I was previously a member of the plan.

(Tick ✓ the relevant box.)

Family Name in Hebrew	Family Name in English

Details of spouse or parent (if the applicant is a minor) who is a member of Maccabi or the Well-Come plan.

ID / Membership No.	Code	First Name	Last Name

Application Date_____

Admission Date _____

For Office Use

Administrative Branch

Branch Tel. No.: _____

Branch Fax No.: _____

Name of Administrator	Signature and Stamp of Administrator

Section B – Personal & Family Details

Adult/s and their children under 18 applying to join the plan.
Attach a copy of the passport or Israeli ID of each family member.

	Code	Darkonaim No.	Given Name in Hebrew	Given Name in English	Date of Birth	Sex	Passport No.	Passport Issuing Date	Place of Passport Issue
Adult 1	9					☐M ☐F			
Adult 2	9					☐M ☐F			
Child 1	9					☐M ☐F			
2	9					☐M ☐F			
3	9					☐M ☐F			
4	9					☐M ☐F			

	Name	Country of Birth	Country of Last Residence	Marital Status	Date of Entry to Israel	Length of Stay in Israel	Reason for Stay in Israel
Adult 1				☐ Single ☐ Divorced ☐ Married ☐ Widowed			
Adult 2				☐ Single ☐ Divorced ☐ Married ☐ Widowed			

Address - Street	Building No.	Entrance	Apt. No.	Neighborhood	City	Zip Code

Postal Address	Telephone	Cellphone	E-mail address

Name and address of Employer in Israel	Phone Number of Employer	Have you previously had health insurance in Israel?	Name of Israeli Insurance Company	Period of Insurance	Reason for Ceasing Insurance
		☐Yes ☐No			

*Subject to the terms and conditions of the Well-Come plan available on the Maccabi website.

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Section C – Health Declaration

Family members over the age of 45 must attach documents attesting to a general physical examination.

Question:	Adult 1	Adult 2	Child 1	Child 2	Child 3	Child 4	Additional Details (Please Attach Documentation)
General Questions **(apply to every family member):**	**Mark N for a negative answer and Y for a positive answer.** If Y, additional details must be provided in the table, with medical documentation attached.						
1. Height							
2. Weight in kg							
3. Waist circumference							
4. Are you a smoker? If yes, for how many years? How many cigarettes per day?							
5. If you have smoked in the past, when did you quit? How many years did you smoke for? How many cigarettes per day?							
6. Are you limited partially or fully in performing independently one or more of the following activities: walking, standing up, sitting down, getting dressed, washing yourself, eating, drinking, controlling your bowels.							
7. Are you suffering or have you suffered from any disease in the past year? Mention which illnesses and when.							
8. Are you taking or have you taken any medication on a regular basis? Mention which medication.							
9. Have you been admitted to a hospital or other medical institution? Mention when, the reason for admission, and the treatment you received.							
10. Have you undergone surgery? When, and what type of surgery?							
11. Are you a candidate for medical treatment that includes surgery or hospitalization?							
12. Do you consume alcohol/drugs?							
13. Have you undergone any special examinations in the last 5 years (MRI, CT, bone scan, mammography)?							
14. Have you undergone any lab and/or medical examination in the last year? Provide the reason, date, and result, including abnormal results.							
15. Do you suffer from any chronic disease (active or dormant)?							
16. Have you been diagnosed with any autoimmune disease, particularly lupus?							
17. Do you suffer or have you suffered from any infectious disease?							
18. In the last six months, have you lost 6kg or more in weight?							
19. Do you suffer from tiredness or chronic fatigue?							
20. Do you suffer from a chronic cough?							
21. Do you know of any medical problem (including birth defects) that affects you and is not mentioned in this declaration?							
22. Have you received special home care services? If so, what and when?							
23. Have you been in a car/work/other accident?							
24. Are you or have you been under medical / developmental / psychological / psychiatric supervision?							
Are you suffering or have you suffered from one or more of the following diseases?							
25. Diseases of the brain and nervous system, paralysis, fainting, epilepsy, movement disorders, psychiatric disorders (TIA, CVA, dementia, Alzheimer's, emotional exhaustion).							
26. Illnesses of the respiratory system, asthma, tuberculosis, chronic lung infection, hemoptysis, COPD, pneumothorax.							
27. Cardiovascular diseases of any kind, high blood pressure.							
28. Diseases of the digestive system, liver, gall bladder, hernia, and hemorrhoids.							

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Question:	Adult 1	Adult 2	Child 1	Child 2	Child 3	Child 4	Additional Details (Please Attach Documentation)
29. Kidney diseases, urinary tract diseases, dialysis.							
30. Bone and joint diseases, neck and back pain. 31. Metabolic diseases, diabetes, thyroid disorder, hyperlipidemia, blood and clotting diseases, anemia.							
32. Cancer. If yes, when?							
33. Skin and sexually transmitted diseases – syphilis, AIDS, persistent sores, herpes of all types, skin growths of all types.							
34. Are you a carrier of or have you been diagnosed with HIV and/or hepatitis?							
35. Eye diseases, ear diseases, hearing/vision impairment, throat diseases, nose diseases, plastic surgery.							
36. Amputations/limb weakness or paralysis.							
37. Degenerative diseases of the nervous or muscular systems (Parkinson's, polio, MS, ALS).							
38. Other.							
Women Only:	**Pregnant women must attach a letter from their gynecologist, including details on the progression of the pregnancy.**						
39. Are you pregnant?							
40. Have you suffered or are you currently suffering from irregular periods, cysts, hemorrhages, breast diseases (including lumps), cervical diseases, or ovarian diseases? Have you undergone an examination to discover cancerous growths, and/or a mammography?							
41. Have you undergone or are you undergoing or do you require fertility treatments?							

Below is space to write in detail about your medical history for positive answers given in the declaration above.

Question No.	Name	Details

I hereby declare that: the purpose of my and my family's stay in Israel is not to receive medical treatment and I do not know of any medical treatment required by myself or any of the family members who are joining the plan with me (With the exception of Covid-19 treatment as much as needed). All the details I have submitted in the health declaration are correct and complete. If it is found that the details I have submitted are not correct and complete, Maccabi will be entitled to revoke my and my family's membership in the program at any time.

Name and Signature of Adult 1 _____ Name and Signature of Adult 2 _____

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Medical Confidentiality Waiver:

I hereby permit any medical institution, including any health fund and/or hospital and/or the National Insurance Institute and/or the IDF and also all its employees and/or doctors to provide Maccabi Healthcare Services, in any manner it requests, with any information it holds related to my state of health and/or any illness I have suffered or may suffer from in the past, present, or future and/or all information included in the medical file opened in my name, for so long as it is necessary to ascertain all rights and obligations, which are determined according to the terms of the Well-Come program.

I hereby relinquish medical confidentiality regarding Maccabi Healthcare Services and release any institution and/or employee from the obligation of maintaining medical confidentiality and I will not have any complaint or claim against it regarding the provision of information.

My request is also valid under the Protection of Privacy Act 1981 and the Patients' Rights Law 1996 and applies to all medical or other information contained in the database of any institution, as aforesaid.

This waiver obligates me, my estate and my legal representatives, and anyone who might represent me, and also applies to my minor children.

Date	Name and Signature of Adult 1	Date	Name and Signature of Adult 2

I hereby declare, consent and agree that:

- All statements are correct, complete, and provided voluntarily.
- I have read the terms and conditions of the plan as displayed on the Maccabi website, and I accept all the terms and conditions stated therein.
- I acknowledge that Maccabi has the authority to either approve or reject my application for membership of the plan, with no obligation to justify its decision.
- I acknowledge that the contract will be in effect only after I have received confirmation from Maccabi of my acceptance to the plan and after the initial membership fees have been paid in full.
- I acknowledge that Maccabi will be exempt from providing care related to a congenital defect/disease, including hereditary diseases and/or my state of health and/or medical event and/or disease, whether treated or not, and/or their results, directly or indirectly, which were caused and/or exacerbated due to a state of health which existed prior to the start date of the membership.
- I acknowledge that the monthly rate is updated periodically according to the terms and conditions of the plan.
- I acknowledge that Maccabi has the authority to determine a supplementary fee to the fixed rate or exclude a medical condition, pursuant to the medical state determined as a condition of the membership's approval.
- I acknowledge that the first payment for the plan is to be paid several months in advance, as stated in the terms and conditions of the plan.
- I acknowledge that the application and health declaration are valid for a month from the day they are signed.
- I acknowledge that, in the event I am subject to a waiting period according to section 58 of the National Insurance Law, I am obliged to update Maccabi regarding the deadline for the end of the waiting period.
- All statements made above also refer to my children who are minors and included in this application.

Supplementary Insurance

- I acknowledge that the Well-Come plan membership fees do not include payment for supplementary insurance or Nursing Gold or Keren Maccabi, and these will be paid in addition.
- I acknowledge and I agree herein that my membership in Magen Zahav and/or Maccabi Sheli is subject to the joining terms that apply to a member of the Well-Come plan.
- I acknowledge that my membership of Keren Maccabi is subject to the terms and conditions of Keren Maccabi.
- I acknowledge that joining the Nursing Gold plan is subject to the terms of the insurance company and the terms of the policy.

I, the undersigned, confirm that I have read and understood the plan's terms and conditions and that all the terms above have been explained to me in the _____ language.

Date	Name and Signature of Adult 1	Date	Name and Signature of Adult 2

For office use:
This proposal was signed by the applicant to the plan after its content was explained in a language understood by him/her.

Name of Medical Service Representative	Signature	Date

Details of Translator to Native Language:

Full Name	ID/Passport No.

Details of Legal Guardian:

Full Name	ID/Passport No.

Applicant declaration, in the event that more than one month but not more than 3 months have passed since the initial signature on this application form:
I hereby declare that no change has occurred in my state of health since I signed the health declaration on _____ and I acknowledge that Maccabi has the authority to request additional medical documents.

Date	Name and Signature of Adult 1	Date	Name and Signature of Adult 2

Please complete, in cases where the submission of the application form, or the arrangement of payment plan to complete the registration process are not made directly by the applicant himself:

I hereby empower _____, ID _____ to perform in my name all the actions required to register myself and my minor children to the Well-Come program.

Date	Name and Signature of Adult 1	Date	Name and Signature of Adult 2

For office use only: ☐ Approved ☐ Rejected Subject to Health Declaration

Name of Administrator: _____ Date: _____

Remarks: _____

In the event of a discrepancy between the wording used in this document and the original Hebrew version, the Hebrew version will prevail.