MIGDAL

Good to Have Migdal by Your Side
Migdal Insurance Company Ltd.

Insured name	Identity No.
Policy No. / Plan	**Claim No.**

The form is designed both for men and women
The form must be filled in with a **pen only** and not with a pencil

Waiver of general and medical confidentiality

A. Details of the declarer and waiver of confidentiality

Identity No.	Last name	First name	Name of the father

Street	No.	App.	P. o. Box	City	Zip code	Telephone No.

I hereby give permission to every medical employee and / or doctor and / or medical institution Including hospitals and mental health clinics, including the Geha Mental Health Center, HMOs, their doctors, employees and / or those on their behalf and / or any employee of the National Insurance Institute And / or the Israel Defense Forces and / or the Ministry of Defense, including the dangling of the profile and / or the Prison Service ,Personal and medical and / or to the Ministry of Education from the Personnel and Treasury Section Details of schools and Academic achievements And / or the Ministry of the Interior and / or the Ministry of Aliyah and / or the Ministry of Absorption and / or the Director of Population and / or the Border Police Clarification of details about a passenger Arrivals and departures from the country And / or the Ministry of Health, including the Medical Cannabis Unit And / or to rehab centers and / or health bureaus, a "tipat HALAV" card and / or nursing homes And / or municipalities, including welfare offices and / or the Road Safety Institute And / or Mor Institute of Medical Information Ltd., M.a.r Institute And / or for every employee in the social field and / or nursing field and / or for every employee in the institutions that manage pension funds,(including members of Makfet and Mivtachim Pension Funds LtdsW) / or to the Ministry of Employment and / or all insurance companies to deliver to _____ (below: "the applicants") And / or a person who presents a letter of authorization to act on their behalf to collect information all the details in the service provider's possession Which will be detailed below without exception and in the manner required by the applicants on their state of health And / or the social and / or psychiatric and / or psychological and / or situation in the field of nursing and / or rehabilitation and / or any illness I have had in the past or I am currently ill with it including information in respect of claims of any kind and / or work accidents and / or road accident and / or earlier and / or late claims including payments the amount of the settlement and its date.

I hereby release all of the above institutions including the HMOs and / or any physician from their physicians and / or any employee employees and / or any institution from their institutions including general hospital and / or psychiatric and / or rehabilitative hospitals and any branch of their institutions including the Mor Institute and / or the Geha Institute and / or the Mental Health Clinic and / or all the government ministries listed above The insurance companies and institutions that manage the pension funds have a duty to maintain confidentiality with regard to health and / or rehabilitative and / or social and / or nursing and / or psychiatric and / or genetic conditions And hereby permits them to provide any information from any case opened in my name including material contained in the databases of the service providers listed below including a full claim file Including the National Insurance Institute, including information on the payments that the National Insurance Institute paid and pays me, including information from the Insurance Continuity Department at the National Insurance Institute I waive this confidentiality towards the applicants and I will not have any claim or claim of any kind in connection with the provision of such information to any of the institutions, including the health funds and / or any of their doctors and / or employees and / or anyone on their behalf and / or their service providers..

This request is also according to the Privacy Protection Law 1981 and any other law that replaced it and / or replaced it and is for any medical or other information contained in the databases of all private / organizational Including the HMOs and / or their doctors and / or employees and / or those on their behalf and / or the service providers listed below.

This waiver obligates me, my legacy, and my legal powerlessness and anyone who comes in my place. The use of the information will be made for the purpose of joining to insurance and settlement of claims only.

B. More details

Name of HMO	Branch	Member No.	Personal number in the IDF	Name of previous HMO

Names of service providers including doctors, institutes, laboratories, schools, kindergartens			
1.	2.	3.	4.

(edition 07.2022)

C. In the case of a minor

Identity No	Last name	First name	Family kinship	Address	Signature of guardian
					★
					★

D. Power of attorney

I hereby assign the representative of a law firm _____ or someone who presents written permission to act on behalf of our company to receive the medical information above.

Date

Signature
(If the insured is a minor, Signature of guardian) ★

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Migdal Group
Insurance & Finance

Document Code: 106

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E. Witness to the signature

I, the undersigned, confirm that on the date _____ Appeared in front of me the insured _____ (Name + ID) and signed this document.

A witness to the signature may be – Insurance Agent / a lawyer / physician / social worker / psychologist / The insurance agent with the agent's stamp and not the insurance agency's stamp - including a photocopy of the agent's license.

Date		**Name of the witness to the signature**		**Identity No.**		**Witness' signature and stamp includes license number** ★	

F. Insured's signature

Date		**name & last name**		**Identity No.**		**Insured's signature** ★	

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