MENORA MIVTACHIM MENORA Mivtachim Insurance Ltd.

Policy Holder's Name	Order/Passport No.	Policy No.

For your Information, you must answer fully, in detail and accurately. Failure to declare the truth may affect and even exempt Menora Mivtachim Ltd. from payment.

13. Life Insurance Health Declaration

Primary Insured			Secondary Insured		
Family Name	First Name	ID No.	Family Name	First Name	ID No.
Sex ○ Male ○ Female	Date of Birth		Sex ○ Male ○ Female	Date of Birth	

No.		Primary Insured	Secondary Insured	Questionnaire
	The following questions should be answered with a ✓ in the corresponding answer column. In any case of a positive answer, attach a suitable questionnaire whose number appears in parentheses ( ) in the body of the statement. If there is a * mark next to the diagnosis, an up-to-date medical certificate from the attending physician relating to the declared problem should be attached. **Applicants aged 65 and over must attach a medical certificate relating to your medical condition including surgeries, regular medications, diagnoses, hospitalizations and imaging test results from the past 5 years.**			
	Are you engaged in challenging sports activities and/or a dangerous hobby? For a list of sports activities/challenging/dangerous hobbies, please visit the Menora website. **If the answer is yes, a questionnaire for dangerous hobbies must be completed.**	○Yes ○No	○Yes ○No	
	Are you a licensed pilot or air crew member? **If the answer if yes, a pilot's questionnaire must be completed.**	○Yes ○No	○Yes ○No	

No.	General Health Status Questionnaire	Primary Insured	Secondary Insured	Questionnaire
	Primary Insured Height in Cm: _______ Weight in Kg.: __________	**Secondary Insured** Height in Cm: _______ Weight in Kg.: __________		
	Primary Insured: Do you smoke or have you smoked within the past two years? ○Yes ○No If yes, specify: ○ Cigarettes ○Cigars ○ Nargila ○ Electronic Cigarettes Number of cigarettes per day: _________	**Secondary Insured:** Do you smoke or have you smoked within the past two years? ○Yes ○No If yes, specify: ○ Cigarettes ○Cigars ○ Nargila ○ Electronic Cigarettes Number of cigarettes per day: _________		
	Please note that as long as you stop smoking for an extended period of two years or more, you can update the company with an appropriate affidavit, so that the possibility of changing the tariffs on the relevant coverages can be examined.			

Each question should be marked "yes" or "no" and if the finding is positive, an appropriate questionnaire should be attached with specifics.

No.	Question	Primary Insured	Secondary Insured	Questionnaire
1.	Do you currently or have you ever consumed more than two portions of alcoholic drink per day? (1)	○Yes ○No	○Yes ○No	**Alcohol Questionnaire - 1**
2.	Do you currently use or have you ever used any type of drug (Do not declare one-time use) (2)	○Yes ○No	○Yes ○No	**Drug Questionnaire - 2**
3.	**Is there any inquiry into a phenomenon or disease that has not yet been completed:** Have you been referred during the last two years and /or are currently undergoing subsequent medical and/or diagnostic tests that have not yet been completed and for which a final diagnosis has not yet been made? Catheterization, mapping, echocardiography, MRI, CT, ultrasound (not as part of pregnancy follow-up), biopsy, occult blood, colonoscopy, gastroscopy? **If yes, medical documents must be submitted at the end of the inquiry and an unequivocal diagnosis must be obtained.**	○Yes ○No	○Yes ○No	
No.	**Have you been diagnosed currently or in the past with a disease, a phenomenon, a related disorder in one or more of the topics listed below:**	**Primary Insured**	**Secondary Insured**	**Questionnaire**
4.	**Brain and nervous system:** ○Nervous system * ○Brain * ○MS * ○Down syndrome * ○Neurofibromatosis * ○Gaucher * ○Muscular degeneration * ○Epilepsy(3) ○Parkinson's * ○Have you consulted a doctor due to complaints of memory loss in the past three years? *	○Yes ○No	○Yes ○No	**Epilepsy Questionnaire - 3 * Doctor's letter**
5.	**Cardio or Cardiovascular disease:** ○Heart(4) ○Blood disease* ○Pulmonary embolism * ○Aneurysm / AVM* ○coagulation disorders(5) ○DVT(5) ○PVD ○Blockage in the carotid arteries (Crotis)*	○Yes ○No	○Yes ○No	**Heart Questionnaire - 4 Blood Vessel Questionnaire - 5 * Doctor's letter**
6.	Problem/disorder/mental illness including depression and anxiety (7).	○Yes ○No	○Yes ○No	**Psychological Questionnaire - 7**
7.	**Recommendation for pharmacological or dietary treatment in the last 10 years due to the following problems:** ○Blood pressure (6) ○diabetes of any type including gestational diabetes(8) ○cholesterol (9) ○triglycerides (9)	○Yes ○No	○Yes ○No	**Blood Pressure Questionnaire - 6 Diabetes Questionnaire - 8 Blood Lipids Questionnaire - 9**
8.	**Cancer and Benign Tumors:** Malignant disease (cancer) / Malignant tumors * ○Benign tumors (11) Cancerous pre-tumors *	○Yes ○No	○Yes ○No	**Benign Tumor Questionnaire - 11 * Doctor's letter**
9.	**Digestive Tract:** ○Stomach (12) ○intestines (12) ○esophagus (12) ○spleen * ○pancreas (12) ○liver disease (13) ○jaundice (13) ○fatty liver (13) ○fistula ○Crohn's / colitis / proctitis (12)	○Yes ○No	○Yes ○No	**Digestive Tract Questionnaire - 12 Liver and Jaundice Questionnaire - 13 * Doctor's Letter**
10.	**Lung and Respiration:** ○Obstructive pulmonary disease (COPD/emphysema) * ○Cystic fibrosis *	○Yes ○No	○Yes ○No	*** Doctor's letter**
11.	**Kidneys and urinary tract:** ○kidneys (15) ○ system/urinary tract (15) ○bladder (15) ○prostate gland (23)	○Yes ○No	○Yes ○No	**Kidney and Urinary Tract Questionnaire - 15 Men's Questionnaire - 23**
12.	**Infectious/Inflammatory/Immune Diseases:** ○AIDS/HIV Carriers* ○uberculosis * ○Sarcoidosis * ○Scleroderma *	○Yes ○No	○Yes ○No	*** Doctor's letter**
	The following questions only apply to medical conditions that have not been asked or declared in previous questions	**Primary Insured**	**Secondary Insured**	**Questionnaire**
13.	Have you had surgery or been advised to have surgery in the last 5 years? (25) **This question should not be answered in the affirmative if the surgery was performed due to a medical problem that you responded to in previous questions**	○Yes ○No	○Yes ○No	**Surgeries and Hospitalization Questionnaire (25)**
14.	Have you been hospitalized for more than three days in the last five years? (25) **This question should not be answered in the affirmative if the hospitalization was performed due to a medical problem that you responded to previous questions**	○Yes ○No	○Yes ○No	**Surgeries and Hospitalization Questionnaire (25)**
15.	Have you been treated and/or are currently being treated with regular medication or has regular medication been recommended to you in the past five years? **This question should not be answered in the affirmative if the drug treatment was taken due to a medical problem that you answered in previous questions** If so, please specify: Name of the drug: _______________ Diagnosis for treatment/ Recommended treatment: _________	○Yes ○No	○Yes ○No	
No.	**In the purchase of a release and/or equal to a complementary future and/or a top umbrella, the following questions should also be answered:**	**Primary Insured**	**Secondary Insured**	**Questionnaire**
16.	**Eyes:** ○Myopia (No. 8 lenses and above) ○Eye disease/problem in the eyes(21) ○Obatitis * ○Blindness(21)	○Yes ○No	○Yes ○No	**Eyes Questionnaire - 21 * Doctor's letter**
17.	**Ear Nose and Throat:** ○ears (22) ○hearing impairment/deafness (22) ○tinnitus ○Meniere's disease ○nose (22) ○throat (22) ○vocal cords (22)	○Yes ○No	○Yes ○No	**EEG Questionnaire - 22**
18.	**Rheumatology and autoimmune diseases:** ○Familial Mediterranean Fever (16) ○Fibromyalgia * ○Chronic Fatigue Syndrome * ○Lupus * ○Gout/Hyperuricemia	○Yes ○No	○Yes ○No	**FMF Questionnaire – 16 * Doctor's letter**
19.	**Orthopedics:** ○Back and Spine (17) ○Decreased Bone Density ○ Fractures (19) ○Knees (18) ○Elbows (18) ○shoulders (18) ○hip joints (18) ○ankles (18) ○joint disease/arthritis *	○Yes ○No	○Yes ○No	**Spinal Cord Questionnaire - 17 Joints Questionnaire - 18 Fractures Questionnaire - 19 * Doctor's letter**
20.	**Women's Questionnaire:** ○Uterine (24) ○ovaries/fallopian tubes (24) ○breast tumors (24) ○endometriosis. Are you pregnant now? ○No ○Yes Your weight before pregnancy: ____________	○Yes ○No	○Yes ○No	**Women's Questionnaire - 24**
21.	Are you limited to one or more of the following: getting up and lying down, getting dressed and undressed, bathing, eating and drinking, controlling the braces, mobility/walking and/or using an accessory or using another person to perform one or more of the listed activities?	○Yes ○No	○Yes ○No	
No.	**When purchasing a Top Keren Or, the following question must also be answered**	**Primary Insured**	**Secondary Insured**	**Questionnaire**
22.	**Family history: To the best of your knowledge, have any of your relatives (father / mother / sisters / brother) been diagnosed with one or more of the following diseases?** ○Heart disease ○Colon cancer ○Ovarian cancer ○Breast cancer ○Prostate cancer ○Diabetes ○Polycystic kidneys ○MS ○Muscular degeneration ○Huntington ○Parkinson ○Alzheimer's	○Yes ○No	○Yes ○No	**In any case of a positive answer, a Family Questionnaire 26 must be attached**

Date: ________ Primary Insured's Signature X_______________	**Date: ________ Secondary Insured's Signature X_______________**