Application for Payment of Burial Fees (Expenses) and Additional Benefits

Applicant information

Insurance card code and number	Code: ●●	Number: XXXX	Name of affiliated office/department	XXXX Co., Ltd., XXXX Branch Telephone number (ext.) 03-1234-5678
Name of applicant	Furigana: ケンポ　ハナコ Hanako Kempo		Applicant date of birth	Showa / Heisei ●● (Y) ●● (M) ●● (D)
Address, telephone number, etc. of applicant (daytime phone number)	〒123-4567 XXXX Condominium, #456　1-2-3 XXXX-cho, XXXX Ward, Tokyo Telephone number 03-7891-2345			
Employee ID number	1234567		E-mail address	XXXX@XXXX.ne.jp

Application details

Date of death	H / R ● (Y) ● (M) ● (D)	Cause of death	Acute heart failure	Was it caused by the actions of a third party? Yes / No

■ For application submitted upon the death of a family member (a dependent)

Name of family member		Date of birth	Showa / Heisei (Y) (M) (D)	Relationship with the insured person	

If you fall under one of the following categories, please enter the name of his/her past insurer, and the health insurance code and number.

(1) Died within 3 months after being qualified as a dependent by this health insurance society

(2) Died while continuing to receive the injury/illness allowance or maternity allowance after being disqualified from this health insurance society to which he/she was previously enrolled

(3) Died within 3 months after the end of receiving (2) after being disqualified from the health insurance to which he/she was previously enrolled

Name of insurer	Phone number ( )
Code and number	

■ For application submitted upon the death of the insured person

Name of insured person	Taro Kempo	Personal relationship between the insured person and applicant	Wife
Date of funeral		Burial expenses	yen

If you fall under one of the following categories, please enter name of the insurer and the code and number of the health insurance in which the deceased had been enrolled after retirement.

(1) Died within 3 months after being disqualified from this health insurance due to retirement, etc.

(2) Died while continuing to receive the injury/illness allowance or maternity allowance from this health insurance society after being disqualified

(3) Died within 3 months after the end of receiving (2) after being disqualified

Name of insurer	Phone number ( )
Code and number	

Column to be certified by the business owner

I

Please ask your employer for a certificate for this section. If you cannot receive a certificate, please attach documents which prove that death occurred (death certificate, burial permit, etc.).

*If you wish to delegate receipt, please complete the authorization letter.

Authorization Letter

☐(1) I hereby entrust the receipt of benefits based on this claim to the employer. ← Insert a check (☑) in the box of the applicable item.

☑(2) I hereby entrust the receipt of benefits based on this claim to the representative listed below. Reiwa ●(Y) ●(M) ●(D)

Insured person (applicant)	Name	
Representative (individual actually receiving benefits)	Name	Hanako Kempo

Information on transfer destination

Name of financial institution	○○○	Bank / Shinkin bank (credit treasury)	○○○	Central branch / Branch	Branch number: 123
Type of account	Savings account / Checking account	Account number: 0123456	Name of account holder (Katakana): Hanako Kempo		

Remarks

Individual number (not required when entering the code and number from the insured person's card)

*If you entered your individual number, please attach the following documents to confirm your individual number and identity.

One of the following: (1) Copy of individual number notification card, (2) Copy of certificate of residence listing individual number, (3) Copy of individual number card (both sides)

・When attaching (1) or (2) above, also attach one of the following: copy of driver's license or copy of passport

Section to be completed by the labor and social security attorney submitting the application on behalf of the insured	

Date request received (stamp)

Mercari Health Insurance Association

Application for Payment of Burial Fees (Expenses) and Additional Benefits

Applicant information

Insurance card code and number	Code: ●●	Number: XXXX	Name of affiliated office/department	XXXX Co., Ltd., XXXX Branch Telephone number (ext.) 03-1234-5678
Name of applicant	Furigana: ケンポ タロウ Taro Kempo (Kempo)		Applicant date of birth	Showa / Heisei ●● (Y) ●● (M) ●● (D)
Address, telephone number, etc. of applicant (daytime phone number)	〒123-4567 XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, Tokyo Telephone number 03-7891-2345			
Employee ID number	1234567		E-mail address	XXXX@XXXX.ne.jp

Application details

Date of death	H / R ● (Y) ● (M) ● (D)	Cause of death	Acute heart failure	Was it caused by the actions of a third party?	Yes / No

■ For application submitted upon the death of a family member (a dependent)

Name of family member	Hanako Kempo	Date of birth	Showa / Heisei ● (Y) ● (M) ● (D)	Relationship with the insured person	Wife

If you fall under one of the following categories, please enter the name of his/her past insurer, and the health insurance code and number.

(1) Died within 3 months after being qualified as a dependent by this health insurance society

(2) Died while continuing to receive the injury/illness allowance or maternity allowance after being disqualified from this health insurance society to which he/she was previously enrolled

(3) Died within 3 months after the end of receiving (2) after being disqualified from the health insurance to which he/she was previously enrolled

Name of insurer	Phone number ( )
Code and number	

■ For application submitted upon the death of the insured person

Name of insured person		Personal relationship between the insured person and applicant	
Date of funeral		Burial expenses	yen

If you fall under one of the following categories, please enter name of the insurer and the code and number of the health insurance in which the deceased had been enrolled after retirement.

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Name of insurer	Phone number ( )
Code and number	

Column to be certified by the business owner

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Insured person (applicant)	Name	Taro Kempo
Representative (individual actually receiving benefits)	Name	

Information on transfer destination

Nam

Typ

Please fill in the section for the authorization letter, except for persons enrolled in voluntary and continuous health insurance coverage and retirees.

If you are a person enrolled in voluntary and continuous health insurance coverage or a retiree, please fill in the section for information on transfer destination.

Remarks

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*If you e

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Section to be completed by the labor and social security attorney submitting the application on behalf of the insured	

Date request received (stamp)

Mercari Health Insurance Association