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

			_								
	Insurance card	Code Numb		iber N		Name of affiliated		XXXX Co., Ltd., XXXX Branch			
g.	code and number		XX	XX	off	office/department Tel		ne numbe	r (ext.) 03-12	234-5678	
ormatio		Furigana	 ケンポ ハナ	<u> </u>				iic iiuiiioci	(CAL.) UJ-12	234-3070	
	Name of applicant				Ap	plicant date of	Showa	••	(Y) • (I	M) • (D)	
inf		Hanako Kempo				birth					
Applicant information	Address, telephone number, etc. of applicant (daytime phone number)	T 123-4567 XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, Tokyo Telephone number 03-7891-2345									
1	Employee ID number			Е	E-mail address XXXX@XXXX.ne.jp				e.jp		
	Date of death	HR (Y	Cause of dea	ath	Acute h	eart fa	t 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) (I	M) (D)	Relationship with the insured person			
	If you fall under one of the foll	owing categories, pleas	se enter the name of his/h	er past insurer, and the	health i	nsurance code and numb	oer.	Name of	P	l.	
ils	(1) Died within 3 months after	being qualified as a de	surance society				insurer	Phone number	()		
Application details	(2) Died while continuing to receive the injury/illness allowance or maternity al society to which he/she was previously enrolled (3) Died within 3 months after the end of receiving (2) after being disqualified enrolled			• .				Code and number			
licat	■ For application s	ubmitted upon t	the death of the i	nsured person			·				
Appl	Name of insured person		ıpo			nal relationship between ured person and applicant		Wife			
	Date of funeral					Buria expens				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. Name of										
	(1) Died within 3 months after being disqualified from this health insurance due to retirement, etc.							insurer	Phone number	()	
	(2) Died while continuing to receive the injury/illness allowance or maternity allowance from this health i disqualified				th insur	ance society after being	C	Code and			
	3) Died within 3 months after the end of receiving (2) after being disqualified							number			
x											
ified by	Please ask your employer for a certificate for this section.										
ertifiec owner											
be con	If you cannot receive a certificate, please attach documents										
Column to be cert the business ov	which prove that death occurred (death certificate, burial										
lum the	permit, etc.).										
ပိ			<u> </u>						,		
*If you wish to delegate receipt, please complete the authorization letter.											
Authorization Letter	\square (1) I hereby entrust	the receipt of ber	nefits based on this	claim to the emp	loyer.	← Insert a checl	k (☑) in th	e box of the	applicable item.		
on L	∠ (2) I hereby entrust	st the receipt of benefits based on this claim to the represen				ative listed below.	R	leiwa 🛑	(Y) (M)	(D)	
izati	Insured person	(applicant)									
thor	Representa										
Au	(individual actually red		Hanako Kempo								
sfer	N CC : 1			Bank				Central branch	D 1		
Information on transfer destination	Name of financial institution	000		Shinkin bank		000			Branch number	123	
	mstrution			(credit treasury)	1			Branch	number		
	Type of account	Sayings account Checking account		Account number	0123456		acco	Name of ount holder Katakana)	Hanako Kempo		
rks	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.										
Remarks	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)										
R	•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)											

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

	Insurance card	Code Number XXXX		Name of affiliated office/department		XXXX Co., Ltd., XXXX Branch					
	code and number					Telephone number (ext.) 03-1234-5678					
Applicant information		Furigana ケンポ タロウ									
	Name of applicant	Turigana) • N.) =		Applicant date of		Sho				
imfc		Taro Kempo (Kempo)			birth		Hei	Heisei			
ant	Address, telephone	〒123-4567									
plic	number, etc. of applicant (daytime phone number)	XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, Tokyo Telephone number 03-7891-2345									
A	,										
	Employee ID number	1234567			Е	E-mail address XXXX@			@XXXX.ne	XXXX.ne.jp	
										Was it caused by the	
	Date of death	H \bullet $(Y) \bullet (M) \bullet (D)$		Cause of death		Acute	heart failure		actions of a third party? Yes No		
	For application submitted upon the death of a family member (a dependent)								110		
		Palationship									
	Name of family member	Hanako Kempo		Date of birth		Show	(Y)	● (M) ● (D)		Wife	
					Heisei				person		
S		e of the following categories, please enter the name of his/her past insurer, and the health insurance code and number. Name of									
etail		 Died within 3 months after being qualified as a dependent by this health insurance society Died while continuing to receive the injury/illness allowance or maternity allowance after being dis 				d from this health insu	rance	insurer	Phone number	()	
p u	society to which he/she was pr (3) Died within 3 months after	eviously enrolled the end of receiving (2)	after being disqualified	from the health insuran	ce to wl	nich he/she was previo	usly	Code and number			
Application details	enrolled For application s	uhmittad unan t	ha dooth of the i	ngurad pargan			-	number			
plic	Name of insured	ubilitied upon t	ne death of the i	iisured person		5					
A	person					insured person	•	ip between the nd applicant			
	Date of					Bur	ial				
	funeral					expe				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. INATIRE OF INITIAL OF INITIA									
	(2) Died while continuing to re disqualified	Died while continuing to receive the injury/illness allowance or maternity allowance from this health insurance society after being									
								number			
fied by	Dloggo ogk vorm ompleven for a contificate for this section										
		Please ask your employer for a certificate for this section.									
ess (I h	If you cannot receive a certificate, please attach documents									
umn to be certi the business ow	\mathbf{w}	hich pro	ve that d	e that death occurred (death certificat						e, burial	
Column to be certi the business ow	ne	ermit, etc.).									
5 Porting Coops											
	ou wish to delegate r	eceipt, please co	omplete the auth	orization letter.							
Authorization Letter	☑(1) I hereby entrust	the receipt of ben	efits based on this	claim to the emp	loyer.	← Insert a che	ck (🗷) in	the box of the a	pplicable item.		
on L	\square (2) I hereby entrust the receipt of benefits based on this claim to the representative listed below. Reiwa \square (Y) \square (M) \square (D)									D)	
izatio	Insured person (applicant) Name				Taro Kempo						
thori	Representative										
Au	(individual actually red		Name								
fer				Douls				Control brono			
rans	Nam Please f	ill in the s	ection for	the auth	oriz	zation let	ter, e	xcept for	persons	3	
n on matio	enrolled		tary and c					_	_		
nation on tr destination	T CITOREC		tary and t	onunuou	.5 11		ii aiic	e covera,	5c and		
Information on transfer destination	Typ 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.									th insurance	e E	
									on transfe	r 🗀	
•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)											
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