

Managing director	Clerical supervisor		Person in charge

Notification of Change of Insured Person Name

Insurance Code/Number		Emp.No.	Insured Person Name	Gender
				Male
				Female
Date of birth			Address of the insured person	
(Y) (M) (D)				Telephone number

Name <b>after</b> the change		Name before the change		Reason for change
(Furigana)		(Furigana)		
(Last name)	(First name)	(Last name)	(First name)	
(Furigana)		(Furigana)		
(Last name)	(First name)	(Last name)	(First name)	
(Furigana)		(Furigana)		
(Last name)	(First name)	(Last name)	(First name)	
(Furigana)		(Furigana)		
(Last name)	(First name)	(Last name)	(First name)	

※ If any changes need to be made to the information on your "Eligibility Confirmation Document", please attach the "Application for (Re)issuance of Eligibility Confirmation Document" and the "Eligibility Confirmation Document" with your former name listed.

Date: (Y) (M) (D)

Office address
Name of office
Name of employer
Telephone number

Labor and social security attorney submitting the application on behalf of the insured

Date request received (stamp)

To the Executive Head of the Mercari Health Insurance Association