Application for Injury and Illness Allowance

Information on insured person

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	Furigana: ケンポ タロウ Taro Kempo		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

Name of injury / illness	1) Right thigh fracture 2) Right istal radius fracture 3)	Date of injury or onset of illness	H / R ● (Y) ● (M) ● (D) H / R ● (Y) ● (M) ● (D) H / R (Y) (M) (D)
Cause of injury or illness	Lost footing and fell down the stairs at home	Was it caused by the actions of a third party?	Yes / No
Period taken off due to injury/illness	H / R ● (Y) May 1 to May 31, XXXX		31 days
Did you receive remuneration during the period taken off due to injury/illness?	To present	Have received / Have not received	
Will you receive remuneration in the future?	In the future	Will be able to receive / Will not be able to receive	

■ If you answered "Have received" or "Will be able to receive" above, please enter the remuneration payment period and remuneration amount below.

Remuneration payment period	May 2, XXXX to May 10, XXXX		9 days
Amount of remuneration received	96,000 yen	Amount of remuneration that will be received	yen

■ Are you currently receiving or requesting disability pension/disability allowance, old-age pension, etc.? — Currently receiving / Currently requesting / Neither

If you answered "Currently receiving" or "Currently requesting," please complete the following section.

Type of pension, etc.	1. Disability pension 2. Disability allowance 3. Old-age pension 4. Other ( )		
Name of injury / illness		Pension amount	
Basic pension number		Date on which payment commenced	(Y) (M) (D)

■ Are you currently receiving or requesting temporary disability compensation under Industrial Accident Compensation Insurance? — Yes / No

If you answered "Yes," please list the Labor Standards Inspection Office of the payee (entity to which request for compensation was submitted). — Labor Standards Inspection Office

letter.

Authorization Letter

I hereby entrust the receipt of benefits based on this claim to the representative listed below.

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

*If not completed, the money will be transferred to the salary account.

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Name of financial institution	●● Bank	Shinkin bank (credit treasury)	●● Central branch	Branch	Branch number	123
Type of account	Savings account / Checking account / Other ( )	Account number	1234567	Name of account holder (Katakana)	ケンポ タロウ	

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	

Remarks

Date request received (stamp)

■ Please obtain an opinion and certification from the attending physician.

Opinion of the attending physician

Name of patient		Date of injury	H / R (Y) (M) (D)
Name of injury / illness	1)		(Y) (M) (D)
	2)		(Y) (M) (D)
	3)		H / R (Y) (M) (D)
Cause of injury or illness			
Period during which the inability to work has been recognized	H / R (Y) (M) (D) to H / R (Y) (M) (D)	days	Actual number of days of medical treatment (D)
If hospitalized, period of that hospitalization	H / R (Y) (M) (D) to H / R (Y) (M) (D)	days	
Main symptoms of injury/illness, progress summary, treatment details, etc.			
Medical opinion that recognized that work carried out before then could no longer be carried out (based on course of symptoms)			

Please ask the attending physician to complete this section

I hereby certify that the above is true and correct.

Date

Address of medical institution

Name of medical institution

Name of physician

■ Please obtain a certificate from the employer.

Column to be certified by the employer

Name of insured person						
Work status (use the following sym absences)					Days worked	Paid vacation
H / R (Y) (M)	1 2 3 4 5			31	(D)	(D)
H / R (Y) (M)	1 2 3 4 5			31	(D)	(D)
H / R (Y) (M)	1 2 3 4 5			31	(D)	(D)
Did you receive (will you receive) wages for the period listed above?	Yes / No		End of payment period			(D)
Type of salary	Monthly salary / Daily salary / Monthly salary based on daily accumulated salary / Hourly wage / Percentage wage / Other ( )		Calculation of wages: Date of payment	☐ Applicable month ☐ Next month		(D)

Compensation paid for the period above (salary, benefits, etc.)	Payment period	Payment amount	Date of payment
	(Y) (M) (D) to (Y) (M) (D)	yen	(M) (D)
	(Y) (M) (D) to (Y) (M) (D)	yen	(M) (D)
	(Y) (M) (D) to (Y) (M) (D)	yen	(M) (D)
If no payment has been made up to now and will not be made in the future, state the reason			
Method for calculation of wages (deduction for absences, etc.)			

Please ask the employer for a certificate for this section

I hereby certify that the above is true and correct.

Date

Office address

Name of office

Name of employer

[To employers]

- Please enter the working status, wage payment status, etc., for the wage calculation period, including the period when you did not work.
- You do not need to enter the work status if a copy of your attendance record is attached.
- Please attach a copy of your payroll book.