Health Insurance

Date of Acquisition/Loss of Qualification as an Insured Person
Date of Certification/Deletion as a Dependent
Voluntary Continuation of Insurance Premium Payment

Certification Request Application

Managing director	Clerical supervisor		Person in charge

Date:

I hereby request certification regarding the following matter belo

Name of insured person			
	Insured person code and number		
	Name of office		
	Name		
	Address	Postal code	
	Date of birth		

<Matter for which Certification is Desired>

* Please place a check mark in the ☐ next to the matter for which certification is desired, and enter the name of the relevant dependent as well as to whom the certification will be submitted and the purpose of submittal.

☐ Insured person	☐ Date qualification acquired ☐ Date qualification lost ☐ Proof of voluntary continuation of insurance premium payment

☐ Dependent	Date of birth	Matter for certification
	Showa Heisei Reiwa (Y) (M) (D)	☐ Date of certification / ☐ Date of removal
	Showa Heisei Reiwa (Y) (M) (D)	☐ Date of certification / ☐ Date of removal
	Showa Heisei Reiwa (Y) (M) (D)	☐ Date of certification / ☐ Date of removal
	Showa Heisei Reiwa (Y) (M) (D)	☐ Date of certification / ☐ Date of removal
	Showa Heisei Reiwa (Y) (M) (D)	☐ Date of certification / ☐ Date of removal

Where to submit	City / Ward / Other ( )
Purpose of submission	Enrollment in National Health Insurance / Other ( )

I would like the above certificate to be sent to the following address.

Date: Name of insured person _____

Certificate mailing address	☐ Send to the address of the insured person ☐ Send to other address * Please complete the following. Postal code – Phone number ( ) Address Name of addressee (To:)

Mercari Health Insurance Association

Date request received (stamp)