Managing director	Clerical supervisor		Person in charge

Health Insurance Request for Issuance of Certificate Issued for Specific Disease Treatment Application Form

Information on insured person

Insured person	Code	Number	Name of affiliated office/department	Phone number (Ext.)
Name	Furigana		Date of birth	Showa / Heisei (Y) (M) (D)
Address, telephone number, etc. of applicant (daytime phone number)	Postal code			Phone number (Ext.)
E-mail address				

Section for certified person

Person receiving medical care	Furigana	Date of birth	Showa / Heisei / Reiwa (Y) (M) (D)
Address	Postal code		
Telephone number (Daytime telephone number)	Telephone number ( )	Relationship	
Name of illness (Circle the corresponding item)	1. Chronic renal failure for which an artificial kidney is used 2. Congenital factor VIII deficiency disorder for which a blood plasma protein fraction preparation is administered, OR Congenital factor IX deficiency disorder 3. Acquired immune deficiency syndrome for which an anti-viral agent is administered (includes HIV; limited to those as determined by the Minister of Health, Labour and Welfare.)		

Physician's opinion column

I hereby certify that treatment is being provided as described above.

Date:

Address
Medical institution
Name
Name of physician
Telephone number

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 resident's card 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	

I hereby make an application as shown above.

Date: Name of insured person

To the Executive Head of the Mercari Health Insurance Association

Date request received (stamp)