Application for Health Insurance Payment of Medical Care Costs for Insured Person or Dependent
[for overseas medical expenses]

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(999)
Name	Furigana ケンポ タロウ Taro Kempo		Date of birth	●● (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

Person undergoing medical treatment (circle the applicable person)	(Insured person) / Family member (dependent)	Name of person undergoing medical treatment	Taro Kempo
Name of injury / illness	Influenza	Date of birth of person undergoing medical treatment	●● (Y) ●● (M) ●● (D)
Cause and progress of symptoms	I had a high fever and underwent an emergency examination at a hospital while traveling.		
Name of medical institution where examination was conducted	XXXX Clinic	Address of medical institution where examination was conducted	Washington D.C., U.S.A
Period during which medical treatment was conducted	From ● (Y) ● (M) ● (D) to ● (Y) ● (M) ● (D) ● days	If hospitalized during the period listed on the left, the period of that hospitalization	From (Y) (M) (D) to (Y) (M) (D) days
Cost of treatment	USD $200	Content of treatment	Underwent medical treatment and received administration of drugs
Period of overseas travel	From ● (Y) ● (M) ● (D) to ● (Y) ● (M) ● (D) ● days	Purpose of overseas travel	Touring overseas
Was the need for medical care caused by a third party (traffic accident, etc.)?	(No) / Yes	If the need for medical care was caused by a third party, please describe the situation	

*If you wish to delegate receipt, please complete the authorization letter.

Authorization Letter

☑(1) I hereby entrust the receipt of benefits based on this claim to the employer. ← Insert a check (☑) in the box of the applicable item.

☐(2) I hereby entrust the receipt of benefits based on this claim to the representative listed below. Date: ● (Y) ●● (M) ●● (D)

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

Information on transfer destination

Name of fi… institu… | …nber

Type of a…

Please fill in the section for the authorization letter, except for persons enrolled in voluntary and continuous health insurance coverage and 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.

[Documents for …

1. Attending Physicia… s

5. Copy of document…

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 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	

Date request received (stamp)

Works Human Intelligence Health Insurance Society

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