## Claim for Health Insurance Payment of Funeral Expenses (Costs) for Insured Person or Family Member

		Code	Num	nber							
Applicant information	Insurance card	Code	Number		Name of affiliated office/department		XXXX Co., Ltd., XXXX Branch				
	code and number	•• XXXX		XX			Telephone number (ext.) 03-1234-5678(999)				
	Name of applicant				App	blicant date of		••	(Y) •• (N	(I) ●● (D)	
inf		H	anako Kem	ро	birth						
ant	Address, telephone	〒123-4567									
plic	number, etc. of applicant										
Ap	(daytime phone number)			Telephone nu	mber	03-7891-234	-2345				
	Employee ID		1234567	34567		E-mail address		XXXX@XXXX.ne.jp			
	number										
				,	Acute heart		• • •	Was it caused by the actions of a third party?			
	Date of death	(Y) (M) (D) Cause		Cause of dea			ath	allure	Yes No		
	■ For application s	tion submitted upon the death of a family member (a dependent)									
									Relationship		
	Name of family member			Date of birt	th		(Y)	(M) (D)	with the insured		
									person		
10	If you fall under one of the follo	owing categories, please enter the name of his/her past insurer, and the health				surance code and num	ber.	Name of			
tails		r being qualified as a dependent by this health insurance society				from this boolth in our		insurer	Phone number	( )	
ı de		tinuing to receive the injury/illness allowance or maternity allowance after being //she was previously enrolled nonths after the end of receiving (2) after being disqualified from the health insu						Code and			
tion	(3) Died within 3 months after enrolled	the end of receiving (2)	after being disqualified i	from the health insurand	ce to whi	ch he/she was previou	siy	number			
Application details	■ For application su	ubmitted upon t	he death of the i	nsured person							
App	Name of insured		Taro Kem	no		Personal relations the insured pe	•	n	Wife		
1	person			ipo		applic			WIIC		
	Date of					Buri	al			yen	
	funeral					expen			-	yen	
		under one of the following categories, please enter name of the insurer and the code and number of the health insurance in which Name of   sed had been enrolled after retirement. Name of									
		) Died within 3 months after being disqualified from this health insurance due to retirement, etc. insurer Phone number								( )	
	(2) Died while continuing to read disqualified	while continuing to receive the injury/illness allowance or maternity allowance from this health insurance society af ied					after being Code and				
	(3) Died within 3 months after	ithin 3 months after the end of receiving (2) after being disqualified						number			
fied by ner				nlovon fe		aantific	oto f	on this	contion		
	Please ask your employer for a certificate for this section.										
ceri ss o	If you cannot receive a certificate, please attach documents										
o be Isine	which prove that death occurred (death certificate, burial										
Column to be certi the business ow	If you cannot receive a certificate, please attach documents which prove that death occurred (death certificate, burial permit, etc.).										
Solur tł											
	2		•		lovan	— Incont o cho	alt ( <b>Z</b> ) in	the her of the	annliaghla itam		
tter	$\Box$ (1) I hereby entrust the receipt of benefits based on this claim to the employer. $\leftarrow$ Insert a check ( $\square$ ) in the box of the applicable item.										
ıLe	(2) I hereby entrust	the receipt of ber	nefits based on this	s claim to the repr	resenta	tive listed below	v.	Date: 🔴 (	(Y) •• (M)	(D)	
Authorization Letter	Insured pe	Insured person Name									
	(applicat	nt)	Truine								
tho	Represent	Representative			Honeks Varras						
Au	(individual actually receiving benefits)		Name		Hanako Kenpo						
er											
Information on transfe destination	Name of financial	000		Shinkin bank (credit treasury)		000	)	Central branch	Branch	123	
	institution					000		Branch	number	120	
ation estin:								Name of			
orma	Type of account			Account number		0123456	ac			nako Kempo	
Inf	Checking acc		ount ( ) number					(Katakana)			
	Individual number (not required when entering the code and number from the insured person's card)										
urks		-		-	l ual numt	per and identity.					
Remarks		*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)									
Å	• When attaching (1) or (2) abo	•When attaching (1) or (2) above, also attach one of the following: copy of driver's license or copy of passport									
Section to be completed by the labor and social security attorney submitting the application on behalf of the insured											
									l	į	
						1		1			

## Claim for Health Insurance Payment of Funeral Expenses (Costs) for Insured Person or Family Member

Applicant information	Insurance card	Code Nun		nber	Name of affiliated		XXXX Co., Ltd., XXXX Branch Telephone number (ext.) 03-1234-5678(999)			
	code and number		•• XXXX							
	Name of applicant	Taro Kempo			Applicant date of birth			••	(Y) •• (	M) •• (D)
	Address, telephone number, etc. of applicant (daytime phone number)									
	Employee ID number	1234567							XXX@XXXX.ne.jp	
									Was it cau	
	Date of death	• (Y) •	Cause of dea	Cause of death Acute he			failure	Actions of a third party? Yes No		
	For application submitted upon the death of a family member (a dependent)									
	Name of family member	Hanako	Date of bir	Date of birth		● (Y) ● (M) ● (D)		Relationship with the insured person	Wife	
	If you fall under one of the follo	owing categories, please	enter the name of his/h	er past insurer, and the	he health insurance code and number.			Name of		
Application details	· · ·	1) Died within 3 months after being qualified as a dependent by this health insurance society							Phone number	( )
		ontinuing to receive the injury/illness allowance or maternity allowance after bei he/she was previously enrolled 3 months after the end of receiving (2) after being disqualified from the health in						Code and number		
licat	■ For application su	ubmitted upon t	he death of the i	insured person						
App	Name of insured person					Personal relationsh insured person a	-			
	Date of funeral					Burial expenses			yen	
	If you fall under one of the following categories, please enter name of the insurer and the code and number of the health insurance in which the deceased had been enrolled after retirement.									
	1) Died within 3 months after being disqualified from this health insurance due to retirement, etc. insurer Phone number ()									
	(2) Died while continuing to rea disqualified	ile continuing to receive the injury/illness allowance or maternity allowance from this health insurance society after being						Code and		
	(3) Died within 3 months after the end of receiving (2) after being disqualified							number		
In University of the provestigation of the provided p										
	you wish to delegate r	<u> </u>	-							
Letter										
Authorization Letter	Insured person (applicant)		Name			Taro Kempo				
	Representative (individual actually rece Please fill in the section for the authorization letter, except for persons enrolled in									
ısfer	Name of financial						-	-		
Information on transfer destination	institution	voluntary and continuous health insurance coverage and retiree If you are a person enrolled in voluntary and continuous health								
	Type of account	Type of account coverage or a retiree, please fill in the section for information on transfer   destination.								
Inf										
~	Individual number (not require	ed when entering the co	de and number from the	insured person's card)						
Remarks	*If you entered your individual number, please attach the following documents to confirm your individual number and identity.									
Rem	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

Section to be completed by the labor and social security attorney submitting the application on behalf of the insured