Injury and Sickness Benefits Application

Information on insured person

Insurance card code and number	Code	Number	Name of affiliated office/department	Phone number (Ext.)
Name			Date of birth	(Y) (M) (D)
Address, telephone number, etc. of applicant (daytime phone number)	Postal code Phone number (Ext.)			
Employee ID number			E-mail address	

Application details

Name of injury / illness	1)	Date of injury or onset of illness	(Y) (M) (D)
	2)		(Y) (M) (D)
	3)		(Y) (M) (D)
Cause of injury or illness		Was it caused by the actions of a third party?	Yes / No
Period taken off due to injury/illness	(Y) (M) (D) to (Y) (M) (D) 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	(Y) (M) (D) to (Y) (M) (D) days		
Amount of remuneration received	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

*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	
Representative (individual actually receiving benefits)	Name	

Information on transfer destination

Name of financial institution	Bank Shinkin bank (credit treasury)	Central branch Branch	Branch number		
Type of account	Savings account Checking account	Other ( )	Account number	Name of account holder (Katakana)	

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)

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

Opinion of the attending physician

Name of patient		Date of injury or onset of illness	(Y) (M) (D)
Name of injury / illness	1)	Date medical treatment began	(Y) (M) (D)
	2)		(Y) (M) (D)
	3)		(Y) (M) (D)
Cause of injury or illness			
Period during which the inability to work has been recognized	(Y) (M) (D) to (Y) (M) (D) days	Actual number of days of medical treatment	(D)
If hospitalized, period of that hospitalization	(Y) (M) (D) to (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)			

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 your employer.

Column to be certified by the employer

Name of insured person			
Work status (use the following symbols: "◯" for days worked, "△" for paid vacation, "H" for national holidays, and "/" for absences)		Days worked	Paid vacation
(Y) (M)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	(D)	(D)
(Y) (M)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	(D)	(D)
(Y) (M)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	(D)	(D)

Did you receive (will you receive) wages for the period listed above?	Yes / No	Calculation of wages	End of payment period	(D)
Type of salary	Monthly salary / Daily salary / Monthly salary based on daily accumulated salary / Hourly wage / Percentage wage / Other ( )		Date of payment	☐Applicable month ☐ Next month (D)

	Payment period	Payment amount	Date of payment
Compensation paid for the period above (salary, benefits, etc.)	(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.)			

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.

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