The Childbirth and Childcare Lump-Sum Grant additional benefits for Insured Person or Family Member

	lf n	not using the syste			istitutions,					
n	Insurance card	Insurance card Code		mber	Name of a	affiliated				
erse	code and number				office/department					
l pe					office/ue	Partition	Phone nu	mber (E	Ext.)	
red										
nsu	Name				Date of birth			(Y)	(M)	(D)
n ii									- /	. ,
n 0	Address, telephone number,									
ntio	etc. of applicant	plicant					Dhar			
Information on insured person	(daytime phone number)	number)			Phone nu		Phone numb	ber (Ext	.)	
nfor	Employee ID number	Employee ID number			E-mail address					
Π	Employee in humber			E mail address						
	Person who gave birth	Person who gave birth			Norte	f norcon				
	(circle the applicable	Insured perso	Insured person / Family member (dependent)			f person				
	person)				who gave birth					
	Delivery data (V)		(M) (D)		Date of birth			(Y)	(M)	(D)
	Delivery date	(Y)		(M) (D)		o gave birth		(1)	(111)	(D)
	Live birth or stillbirth				Number of		Number of		In the case of a stillbirth,	Weeks:
ils	(circle the applicable			rth / Mixture of live birth and still birth		live-born Baby (ies) s		Baby (ies)	the elapsed period of	() days
leta	type)	type)			babies Relationship between the		babies		pregnancy	
Application details	Name of born baby					erson and born			Is the born baby	Yes
					baby				a dependent?	No
lice	Name of medical			Address of medical						
√pp	institution			institution						
	· ·	where baby was born			where baby was born					
	Complete the following section if applicable									
	1. If the insured person gave birth within six months after				Insured person					
	Insurer's name, code	Insurer's name, code and number, etc., of the insured person who is currently enrolled					Telephone	number	()	
	2. Childbirth by dependent within 6 months after qualification \rightarrow				Code and number					
	Name, code and num	er, etc., of the insured person who was previously enrolled		-						
*If yo	ou wish to delegate receip	pt, please complete	the authorization	letter.						
er	$\Box(1)$ I hereby entrust the 1	receipt of benefits base	ed on this claim to th	he employer. ← Inser	t a check (🗹)	in the box of t	the applicable	item.		
Jett	$\Box(1) \text{ I hereby entrust the receipt of benefits based on this claim to the employer.} \leftarrow \text{Insert a check } (\square) \text{ in the box of the applicable item.}$ $\Box(2) \text{ I hereby entrust the receipt of benefits based on this claim to the representative listed below.} Date: (Y) (M) (D)$									
J nq						Date.	(1)	(191) (L	')	
atic	Insured pe (applicat		Name							
oriz	(applical	nt)								
uthorization Letter	Representa	ative	Name							
Authoriz		ative								
Auth	Representa (individual actually red	ative		Bank				Central branch		
Auth	Representa	ative		Shinkin bank					Branch number	
Auth	Representa (individual actually red	ative ceiving benefits)	Name				Nam	Central branch Branch e of account	Branch number	
Auth	Representa (individual actually red	ative ceiving benefits) Savings accou	nt Other	Shinkin bank				Branch	Branch number	
Information on transfer destination	Representa (individual actually red Name of financial institution	ative ceiving benefits)	nt Other	Shinkin bank (credit treasury)				Branch e of account	Branch number	
Information on transfer destination	Representa (individual actually red Name of financial institution Type of account ertification section (pleas	ative ceiving benefits) Savings accou Checking accou	Name nt Other unt ()	Shinkin bank (credit treasury)				Branch e of account holder	Branch number	
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Works Human Intelligence Health Insurance Society