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

System of receipt of the Childbirth and Childcare Lump-sum Grant directly by the medical institutions on your behalf

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	〒123-4567 XXXX Condominium, #456　1-2-3 XXXX-cho, XXXX Ward, Tokyo			
E-mail address	XXXX@XXXX.ne.jp			

Application details

Person expected to give birth (circle the applicable person)	Insured person / Family member (dependent)	Name of person expected to give birth	Hanako Kempo
Due date and expected number of babies	●● (Y) ●● (M) ●● (D) Single birth　Multiple birth (　babies)	Date of birth for person expected to give birth	●● (Y) ●● (M) ●● (D)
Name of medical facility institution where delivery is expected	XXXX Maternity Clinic	Address of medical facility institution where delivery is expected	3-3-3 XXXX-cho, Yokohama City, Kanagawa Prefecture
■ Complete the following section if applicable 1. If the insured person gave birth within six months after retirement→ Name, code and number, etc., of the insured person who is currently enrolled 2. Childbirth and childcare by dependent within 6 months after qualification→ Name, code and number, etc., of the insured person who was previously enrolled		Insured person	Telephone number (　)
		Code-number	–

*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	Name	

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.

Information on transfer

me of financial insti		ch number	
Type of account			

Remarks

■ The Claim form will b

■ Please attach a copy o

Section to be filled out by the proxy to receive payment

The applicant (　　) (hereinafter, "Party A") hereby designates the medical institution (　　) (hereinafter, "Party B") as its proxy and delegates the following authority to Party B.
Furthermore, Party A shall not make use of the system of direct payment of the Childbirth and Childcare and Childcare Lump-sum Allowance, etc., to medical institutions. Of the Childbirth and Childcare and Childcare Lump-sum Allowance, etc., claimed by Party A, this is related to the receipt of costs* related to Childbirth and Childcare charged to Party A by Party B.
* The upper limit shall be th　　efits in the case that the insured person claims additional be

(Y)

Please ask the medical institution to complete this section.

Financial institution for payment to proxy

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

Works Human Intelligence Health Insurance Society

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