

# Request for Payment of Maternity Allowance

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)	〒			Phone number (Ext. )
	Employee ID number			E-mail address	

Application details	Due date	(Y)	(M)	(D)	Delivery date	(Y)	(M)	(D)	
	Period taken off for childbirth	(Y)	(M)	(D)	to	(Y)	(M)	(D) days	
	Did you receive remuneration during the period taken off due to childbirth? Will you receive remuneration in the future?	To present		Have received / Have not received					
		In the future		Will be able to receive / Will not be able to receive					
	<input type="checkbox"/> 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				

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

Authorization Letter	<input type="checkbox"/> (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.							
	<input type="checkbox"/> (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 number	
	Type of account	Savings account	Other ( )	Account number	Name of account holder (Katakana)			

Certificate from physician or midwife	Name of mother who gave birth		Due date	(Y)	(M)	(D)	Date of delivery	(Y)	(M)	(D)	
	Number of babies born	Single birth	Multiple birth ( babies)	Live birth or Stillbirth	Live birth	Stillbirth (XXth month or XXth week of pregnancy)					
	I hereby certify that the above is true and correct.								(Y)	(M)	(D)
Address of medical facility Name of medical facility Name of physician or midwife											

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 a certificate from the employer.

Column to be certified by the business owner	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	days	days
	(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	days	days
	(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	days	days
	(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	days	days
	(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	days	days
	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			Date of payment		<input type="checkbox"/> Applicable month <input type="checkbox"/> Next month		(D)																						
		Hourly wage		Percentage wage		Other ( )																													
Compensation paid for the period above (salary, benefits, etc.)	Payment period						Payment amount			Date of payment																									
	(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.										(Y)	(M)	(D)																							
Address Name of employer Employer Name Telephone number																																			

[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.