

Managing director	Clerical supervisor		Person in charge

Health Insurance Request for Issuance of Certificate Issued for Specific Disease Treatment Application Form

Information on insured person	Insurance card	Code 100	Number ○○○○○	Name of affiliated office/department XXXX Co., Ltd., XXXX Branch Telephone number (ext.) 03-1234-5678 (123)
	Name	Furigana ケンポ タロウ Taro Kempo	Date of birth 60 (Y) May (M) 20 (D) Showa Heisei	
	Address, telephone number, etc., of applicant (daytime phone number)	〒 XXX-XXXX XXXX Condominium, #201 1-1-2 XXXX-cho, XXXX Ward, Tokyo Telephone number 03-9876-5432		
	E-mail address	XXXX@XXXX.ne.jp		

Section for certified person	Person receiving medical care	Furigana ケンポ ハナコ Hanako Kempo	Date of birth 62 (Y) December (M) 12 (D) Showa Heisei Reiwa	
	Address	〒 XXX-XXXX xxxxx Condominium #201 1-1-2 xxxxx-cho, xxxxx-ku, Tokyo		
	Telephone number (Daytime telephone number)	Telephone number 03(○○○○)○○○○	Relationship Wife	
	Name of illness (Circle the corresponding item)	<input checked="" type="radio"/> 1. Chronic renal failure for which an artificial kidney is used <input type="radio"/> 2. Congenital factor VIII deficiency disorder for which a blood plasma protein fraction preparation is administered, OR Congenital factor IX deficiency disorder <input type="radio"/> 3. Acquired immune deficiency syndrome for which an anti-viral agent is administered (includes HIV; limited to those as determined by the Minister of Health, Labour and Welfare.)		

Physician's opinion column	I hereby certify that treatment is being provided as described above.
	Date: <div style="border: 1px solid red; padding: 20px; display: inline-block; text-align: center;"> <p>Please ask the physician to complete this section</p> </div> Name of physician

Remarks	*Individual number (voluntary)
	*If you entered your individual number, please attach the following two documents to confirm your Individual number and identity. (1) Copy of individual number notification card or copy of certificate of residence listing Individual number (2) Copy of driver's license or copy of passport

I hereby make an application as shown above.

Date:

Name of insured person **Taro Kempo**

Date request received (stamp)

To the Executive Head of the Works Human Intelligence Health Insurance Society