Health Insurance Insured Family Lump-sum Payment for Childbirth/Childcare

1 2

Entered by insured (applicant)

Information on Insured (Applicant)

	Symbol	Number	Date of birth YY MM DD
Insurance Card (Aligned to the right)			☐ Showa ☐ Heisei
Name			
Address	(Postal code –) To Do Fu Ken		
Phone No. (Daytime contact)	TEL ( )		

☐ I delegate the submission of this Request to Employer. (In case of delegation, put a check in the box.)

Designated Bank Transfer A/C

Name of financial institution	Bank / Shinkin Bank / Credit Union / Agricultural Coop / Fishery Coop / Others ( )		Head Office / Branch / Local office / HQ. / Sub-office
Deposit type	☐ 1. Ordinary 2. Current 3. Separate 4. Call	A/C No.	Please enter aligned to the left.
Account name	▼ In *katakana* (Please leave one space between the first and last names, and enter symbols "゛" and "゜" as one character.)	A/C category	☐ 1. Applicant 2. Agent

Receiving Agent Section

Insured (Applicant)	I hereby authorize the following agent to receive benefits based on this Request. Name	Reiwa YY MM DD Address: Same as the address in "Information on insured (applicant)"
Agent (Account holder)	(Postal code –) TEL ( ) Address Name	Relationship between mandator and agent

A form "Entered by insured (applicant)/doctor/ municipality mayor " continues on page 2. ->>>

(R2.12)

Name of submitting Labor and Social Security Attorney	Stamp of receipt date

The personal information you provide is gathered to help the Bosch Health Insurance Society undertake its operations fairly and in accordance with the Health Insurance Act and relevant notifications. Under no circumstances will this personal information be provided to a third party or used for any purpose other than those stated above. In certain cases, we may contact you to seek clarification of details you have provided, or, if necessary, ask you to provide additional supporting documentation. Please address all inquiries concerning the handling of personal information, requests for disclosure of personal information, and so forth to the General Affairs Section of the Bosch Health Insurance Society (telephone: 0493-22-0890).
*To find out more about how we handle personal information, please refer to the "Privacy Policy" on our website.

Health Insurance Insured Family Lump-sum Payment for Childbirth/Childcare

1 2

Entered by applicant/doctor/mayor of municipality

Name of insured

Application Detail

1. Person who gave birth	☐ 1. Insured 2. Family member (dependent)			
1-(i) In case of family member	Name		Date of birth	☐ Showa ☐ Heisei ☐ Reiwa ☐☐ YY ☐☐ MM ☐☐ DD
2. Date of delivery	Reiwa ☐☐ YY ☐☐ MM ☐☐ DD			
3. Live birth or stillbirth	☐ 1. Live birth 2. Stillbirth 3. Live birth / Stillbirth mixed			
3-(i) Number of newborn for "Live birth"	☐ pers.	3-(ii) Number of stillborn for "Stillbirth"	☐ pers.	3-(ii)-(1) Elapsed time of pregnancy in case of "stillbirth" Full ☐☐ weeks
4. Medical institution, etc. delivered	Name		Location	
5. Person who gave birth ● Insured ➡ Did you give birth within 6 months from the date of resignation? ● Family member ➡ Has the baby been born within 6 months after joining our society?	☐ 1. Yes 2. No			
5-(i) If "Yes," enter the "Name of Insurer" and "Symbol/Number". ● Insured ➡ Insurer currently subscribed to ● Family member ➡ Insurer subscribed prior to joining our society	Name of Insurer			
	Symbol/ Number			
5-(i)-(1) For the above childbirth, Lump-sum Payment for Childbirth/Childcare from Insurer in 5-(i) is:	☐ 1. Received / To be received 2. Not received			

Certification Section (Fill in one of the boxes)

Certified by doctor/midwife

Name of person giving birth		Date of delivery	Reiwa ☐☐ YY ☐☐ MM ☐☐ DD
Number of newborn	☐ Single birth ☐ Multiple birth ➡ (chldn.)	Live birth or stillbirth	☐ Live birth ☐ Stillbirth ➡ (weeks pregnant)

I hereby certify that there is no discrepancy as described above.
Reiwa YY MM DD

Location of medical institution
Name of medical institution
Name of doctor/midwife

Certified by municipality mayor (production only)

Registered domicile			Name of head householder	
Name of mother		Name of newborn	Date of birth	Reiwa ☐☐ YY ☐☐ MM ☐☐ DD

I hereby certify that there is no discrepancy as described above.
Reiwa YY MM DD

Name of municipality mayor

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☐ This notification meets the requirement (i) or (ii). (Please put a check in the box.)

(i) This Request is prepared by the applicant (insured).

(ii) The applicant confirmed that the contents are correct.

Bosch Health Insurance Society