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

1 | 2

Entered by insured (applicant)

Information on Insured (Applicant)

Field	Entry
Insurance Card (Aligned to the right) — Symbol	1 0 0 1
Insurance Card — Number	3 4 5 6 7
Date of birth (YY MM DD)	☐ Showa ☑ Heisei — 02 04 15
Name	Kenpo BOSCH
Address	(Postal code 224 – 8501) Kanagawa To Do Fu Ke (Ke circled) Yokohamashi Tsuzukiku Ushikubo 3-9-1
Phone No. (Daytime contact)	TEL 090 (1234) 5678

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

Designated Bank Transfer A/C

Field	Entry
Name of financial institution	SMBC Shintaku — Bank (circled) / Shinkin Bank / Credit Union / Agricultural Coop / Fishery Coop / Others ( )
Branch	Yokohama — Head Office / Branch (circled) / Local office / HQ. / Sub-office
Deposit type	1 (1. Ordinary 2. Current 3. Separate 4. Call)
A/C No.	1 0 0 1 3 4 — Please enter aligned to the left.
Account name	▼ In *katakana* (Please leave one space between the first and last names, and enter symbols "ﾞ" and "ﾟ" as one character.) K e n p o B o s c h
A/C category	1 (1. Applicant 2. Agent)

Receiving Agent Section

Insured (Applicant)	I hereby authorize the following agent to receive benefits based on this Request. Reiwa YY MM DD Name 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.

Bosch Health Insurance Society

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

1 2

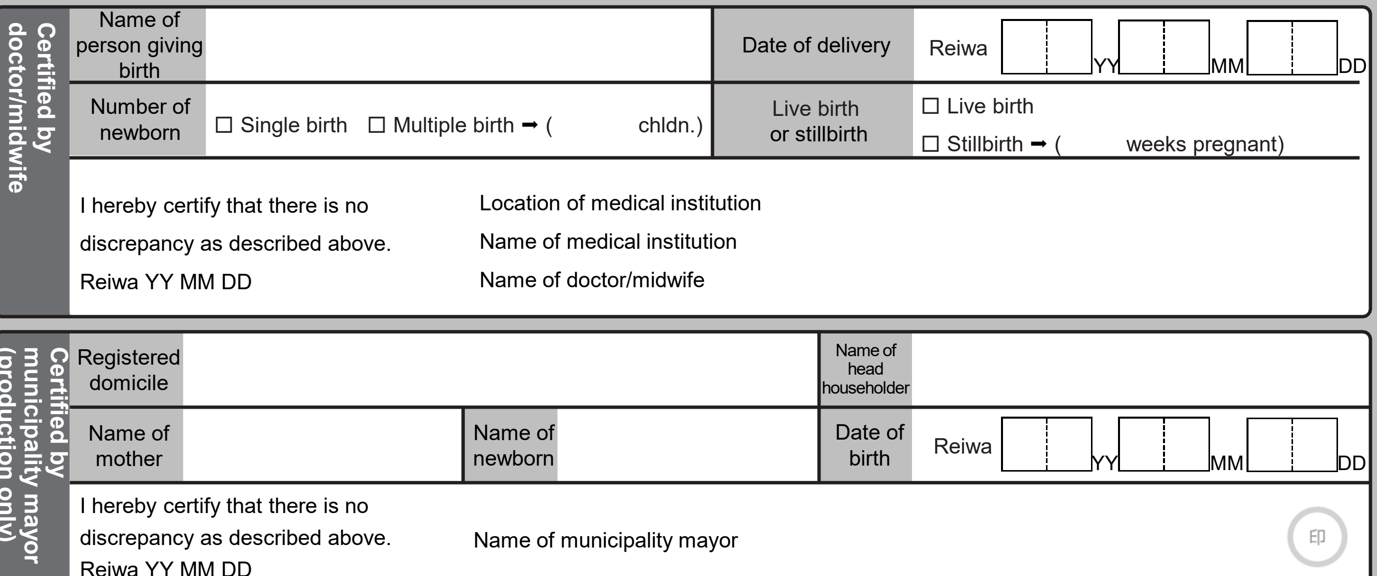
Entered by applicant/doctor/mayor of municipality

Name of insured	Kenpo BOSCH

Application Detail

1. Person who gave birth	1 — 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 0X YY 03 MM 15 DD
3. Live birth or stillbirth	1 — 1. Live birth 2. Stillbirth 3. Live birth / Stillbirth mixed
3-(i) Number of newborn for "Live birth"	1 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: ○○Hospital; Location: Tokyoto Minatoku △△6-7-8
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?	2 — 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 印

☑ 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