# Health Insurance — Insured / Family — Lump-sum Payment for Childbirth/Childcare — Internal Payment Request / Balance Request

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. Reiwa YY MM DD<br>Name<br>Address: Same as the address in "Information on insured (applicant)" | |
| Agent (Account holder) | (Postal code — ) TEL ( )<br>Address<br>Name | Relationship between mandator and agent |

☐ 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.

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 Internal Payment Request Balance Request

Entered by applicant/doctor/mayor of municipality

| Name of insured | |
|---|---|

## Application Detail

| Item | Entry |
|---|---|
| 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<br>● Insured ➡ Did you give birth within 6 months from the date of resignation?<br>● 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”.<br>● Insured ➡ Insurer currently subscribed to<br>● Family member ➡ Insurer subscribed prior to joining our society | Name of Insurer: ___<br>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<br>☐ 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

[In the case of submitting as Internal Payment Request]
Please obtain a certificate of birth by doctor/midwife, or a certificate of matters entered in the family register regarding the birth from municipality mayor.
In the case of stillborn, obtain a certificate issued only by doctor/midwife. Provided, however, that if the “Date of delivery” and “Number of newborn” are indicated on the receipt/statement issued by the medical institution, etc., or if the “Date of stillborn” and the “Weeks pregnant” are indicated in the case of stillbirth, certificates shall not be required.

[In the case of submitting as Balance Request]
A certificate of birth by doctor/midwife, or a certificate of matters entered in the family register regarding the birth from municipality mayor shall not be required.

Bosch Health Insurance Society