Messrs. Bosch Health Insurance Society,

Health Service Expense Bill



[Applicant	(Insured Pers	son)】	Date: (M) 5 (D) 15 , (Y) 2024					
Insurance Card	Symbol 9999		Insured Person's	Kappa Tara				
	No.	99999	Name	Kenpo Taro				
Site Name			±-► ∧ +1	Contact Phone No.				
(Company Name)			朱式会社	03-456-7890				
Present								
Address								

Please put a circle mark "O" on the number of an applicable item and fill in the information regarding the medical institution.

☆ Please be sure to attach herewith the receipt issued by the medical institution which evidences your payment.

[Billing Item] (for a voluntarily continued insured persons)

1 An influenza vaco			2 Gynecological exami			3	3	Other (examination)	
Status										
Vaccinated Person's Name Relationship		Date of Vaccination		Name of Medical Institution			Expense			
Kenpo Taro		yyyy/mm/dd		〇〇〇 総合病院				4,000	円	
									円	
									円	
					Am	ount of			円	
ease fill this column when you assign receiving of the billed amount. (M)										
om that of the applicar				site etc						
eiving of the		Name of Agent								
	(Name of the account to which the billed amount is paid)									
	e allowanc	e (contribu	ition amo	unt) determined k	y Bosc	h Heal	th Ins	surance Society is trans	ferred	
anking Institution Branch Name /Bank code /Branch code			imes imes imes Bank			Higashimatsuyar				
Deposit Item / Account No.			Ordinary Account / Current Account			Account No. 1234567				
Furgana Account Holder's Name			タロウ							
	Status] n's Name Relationship arro arro arro en you assign receivir either in case the bar m that of the applicar you. eiving of the umber to which the it.) Branch Name /Branch Name /Branch code Account No. ana der's Name	Status Relationship Date on's Name Relationship Date `aro	Status] Relationship Date of Vaccir `aro yyyy/mm/d en you assign receiving of the billed amount. either in case the bank account to which the bilm that of the applicant (the insured person) or i you. eiving of the	Status] Date of Vaccination `aro yyyy/mm/dd `aro yyyy/mm/dd `aro yyyy/mm/dd aro aro aro aro <	Status] n's Name Relationship Date of Vaccination Name of M `aro yyyy/mm/dd OOO 総合 `aro yyyyy/mm/dd OOO 総合 `aro yyyyy/mm/dd OOO 総合 `aro wyyyy/mm/dd OOO 総合 `aro wyyyy'mm/dd OOO `aro watch wyyy'mm/dd `aro wyy'mm/dd `aro wyy'mm/	Status] In's Name Relationship Date of Vaccination Name of Medical `aro yyyy/mm/dd ○○○ 総合病院 `aro yyyy/mm/dd ○○○ 総合病院 `aro yyyy/mm/dd ○○○ 総合病院 ether in case the bank account or which the billed amount. E either in case the bank account to which the billed amount will be m that of the applicant (the insured person) or in case the site etc 'you. Name of Applic (Insured Person) eiving of the	Status] In's Name Relationship Date of Vaccination Name of Medical Instit 'aro yyyy/mm/dd ○ ○ 総合病院 'aro yyyy/mm/dd ○ ○ 総合病院 Bosch Fie Determined Amount of Anount of the applicant (the insured person) or in case the site etc Name of Applicant: (Insured Person) either in case the bank account to which the billed amount will be material of the applicant (the insured person) or in case the site etc Name of Applicant: (Insured Person) eiving of the	Status] In's Name Relationship Date of Vaccination Name of Medical Institution `aro yyyy/mm/dd ○○○ 総合病院 `aro yyyy/mm/dd ○○○ 総合病院 Bosch Healtif Field (Pl Determined Amount of Allowance M(M) en you assign receiving of the billed amount. (M) either in case the bank account to which the billed amount will be 'you. Name of Applicant: (Insured Person) eiving of the	Status] examination In's Name Relationship Date of Vaccination Name of Medical Institution Expense 'aro yyyy/mm/dd Image: Status in the imag	

The information which you filled is for collected the purpose of our society to operate our service accurately and fairly according to Health Insurance Act and other related notices of authorities. We don't use the personal information for other purposes than this purpose, nor provide it to the third parties. In the meanwhile, there is an opportunity that we may ask you for further details about the information which you filled and for the additional evidencing documents, if necessary. For further question on the handling of the personal information or if you have a request for information disclosure and so on, please contact Bosch Health Insurance Society General Affairs Section (Phone 0493-22-0890).

% As for the handling of personal information, please also see the home page, "Personal Information Protection Policy".