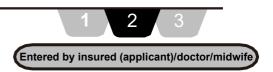
Health Maternity Allowance Insurance Payment Request



n		Symbol		Numb	er	Date of birth YY MM DD					
ormation	Insurance Card (Aligned to the right)					☐ Showa ☐ Heisei					
Information on Insured (Applicant)	Name										
d (App	Address	(Postal code	-)	(To Do (Fu) Ken						
olicant)	Phone No. (Daytime contact)										
	□ I delegate t	the submission of this Request to Employer. (In case of delegation, put a check in the box.)									
Designate	Name of financial institution			Bank (Agri Others	Shinkin Credit Union Coop Coop	Head Office Branch (Local office) HQ. (Sub-office)					
ed Bank 1	Deposit type	1. Ord 2. Cur		A/C No.		Please 6	enter aligned to the left.				
Designated Bank Transfer A/C	Account name	▼ In katakana (F character.)	Please leave one space betw	een the first and	last names, and enter symbols "" " and ""	"as one A/C catego					
	₽ I	a YY MM DD									
	Receiving Agen	Insured	this Request.			Address: Same as the address in "Information on insured (applicant)"					
	t Sect	Agent	(Postal code	_	-)TEL ()	Relationship between mandator and agent				
	ă		Name								
			A-\$	into real le	vinguad (applicant)/de	ot o u/mish vife?	antinuos an nama 2				
			A form "E	nterea b	y insured (applicant)/do	ctor/midwife" co	ontinues on page 2>				
							(R2.12)				
L	ame of submittin .abor and Social Security Attorney	Ĭ.					Stamp of receipt date				
acc a th you har	cordance with the He nird party or used for I have provided, or, it	alth Insurance Act any purpose othe f necessary, ask y ormation, requests	t and relevant notification or than those stated above ou to provide additional s of for disclosure of person	s. Under no ci e. In certain ca supporting doc	ance Society undertake its operation rcumstances will this personal informases, we may contact you to seek claumentation. Please address all inquirand so forth to the General Affairs S	nation be provided to arification of details ries concerning the					

Health Maternity Allowance Insurance Payment Request



Application Detail	1. Is this matern	ity allowance requested before or after childbirth?	1. Request before birth 2. Request after birth								
	delivery.	f "Request before birth," enter the expected date of	Expected date of delivery Reiwa YY MM DD								
tail	dates of deliv	f "Request after birth," enter the expected and act very.	Date of delivery Reiwa YY MM DD								
			From Reiwa YY MM DD								
	3. Period of leav	ve due to childbirth (application period)	To Reiwa YY MM DD								
	to childbirth (a	ve any remuneration for the above leave period d application period)? ceive it in the future?	1. Yes 2. No								
	5. Number of ne	ewborn	Single birth (Multiple birth) (chldn.)								
Ente	Name of persor giving birth										
Entered by doctor/midwife	Expected date of delivery	Reiwa YY MM DD	Date of delivery Reiwa YY MM DD								
docto	Number of newborn	Single birth Multiple birth (chldn.)	Live birth or stillbirth Live birth Stillborn (weeks pregnant)								
r/mid	I hereby certify the	at there is no discrepancy as described above.	Reiwa YY MM DD								
vife	Location of medical institution										
	Name of medical	institution									
	Name of doctor/m		TEL ()								

A form "Entered by Employer" continues on page 3. ->>>

☐ 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.

Health Maternity Allowance Insurance Payment Request



Please enter the attendance and wage payment status for the wage calculation period, including non-working period.

Certified by Employer		Name of insured													
fied b	For attendance status, indicate "O" for attendance, "△" for paid leave, "P" for public holiday, and "/" for absent.								Attendance	Paid leave					
< Π	Reiv	wa YY MM	12345	6 7 8	9 10 11 12	13 14	15 16 17 1	8 19 20 21 22	23 24 25 26 27	28 29 3	30 31	٦	ΓtΙ.	days	days
35	Reiwa YY MM		12345	5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 3				30 31	٦	ΓtΙ.	days	days			
	Reiwa YY MM		12345	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30						30 31	٦	ΓtI.	days	days	
٦ _	Reiwa YY MM 12		12345	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30					30 31	٦	ΓtΙ.	days	days		
	Reiwa YY MM		12345	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 3						30 31	7	ΓtI.	days	days	
	Did you (will you) re		receive any		□ Yes	Typo	of salary	☐ Monthly w ☐ Hourly wa ☐ Daily wage	e		/age	Closing date	1		day
Ì	wag	jes for the abo	es for the above period?		□ No	Туре	or salary	☐ Commission ☐ Daily-base ☐ Others	on ed monthly wage		ulation	Date of paymen		☐ Current month ☐ Next month	day
	Ξnte	er the wages in	ncurred in a v	vage	e calculatio	n perio	od includir	ng the above	period.						
I		Period Category	Unit Price	For MM DD - MM DD		For MM DD - MM DD		For MM DD - MM DD		Please enter the wa method (e.g., method deductions for leave		od	of calcula	ating	
	Details of wages incurred (ac	J9)		Amount paid on MM DD			Amount paid on MM DD		Amount paid on MM DD						
		Base salary												wance is paid for	
		Commuting allowance									multiple for leave				
•		Housing allowance									of calculating the deduction, fill relevant month even if it has alr				in the
		Dependent allowance									been paid.			i it nas an	eauy
		Overtime allowance									yen fo			m	nonths
		Allowance									For MM		-	- MM	
	(accrued)	Total									Date of paymen	t			
	Reiwa YY MM DD Staff name I hereby certify that there is no discrepancy as described above.														
ļ															
					-										
		tion of business													
Name of business office Name of Employer TFI (\							
		. S. Employof							TEL			()	

When correcting the information entered, please cross out the corrected part with a double line and provide the correct information and the name (signature) of certifier.