Health Insurance Maternity Allowance Payment Request

1 2 3

Entered by insured (applicant)

Information on Insured (Applicant)

Insurance Card (Aligned to the right)	Symbol: 1 0 0 1	Number: 3 4 5 6 7
Date of birth	☐ Showa ☑ Heisei	YY MM DD: 0 2 0 4 1 5
Name	Kenpo BOSCH	
Address	(Postal code 224 — 8501) Kanagawa To Do Fu Ke	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

Name of financial institution	SMBC Shintaku	Bank / Shinkin Bank / Credit Union / Agricultural Coop / Fishery Coop / Others ( )
	Yokohama	Head Office / Branch / 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/midwife" 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 Maternity Allowance Payment Request

1 2 3

Entered by insured (applicant)/doctor/midwife

Application Detail

1. Is this maternity allowance requested before or after childbirth?	2 — 1. Request before birth 2. Request after birth
2. In the case of "Request before birth," enter the expected date of delivery. In the case of "Request after birth," enter the expected and actual dates of delivery.	Expected date of delivery Reiwa YY MM DD XX 04 21 Date of delivery Reiwa YY MM DD XX 04 22
3. Period of leave due to childbirth (application period)	From Reiwa YY MM DD XX 03 11 To Reiwa YY MM DD XX 06 17 99 days
4. Did you receive any remuneration for the above leave period due to childbirth (application period)? Or will you receive it in the future?	2 — 1. Yes 2. No
5. Number of newborn	Single birth (circled) Multiple birth (chldn.)

Entered by doctor/midwife

Name of person giving birth			
Expected date of delivery	Reiwa YY MM DD	Date of delivery	Reiwa YY MM DD
Number of newborn	Single birth Multiple birth (chldn.)	Live birth or stillbirth	Live birth Stillborn (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 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.

☑ 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 Employer" continues on page 3. ->>>

In case you need, you can submit this payment request "before birth" and "after birth" separately. In this case, please obtain a certificate of employer each time. If a certificate of doctor/midwife was entered for "before birth" submission and we can confirm the delivery date and so on, you do not have to obtain it for "after birth" submission.

Health Insurance Maternity Allowance Payment Request

1 2 **3**

Entered by Employer

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

Certified by Employer

Name of insured	

For attendance status, indicate "○" for attendance, "△" for paid leave, "P" for public holiday, and "/" for absent.			Attendance	Paid leave
Reiwa YY MM	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 31	Ttl.	days	days
Reiwa YY MM	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 31	Ttl.	days	days
Reiwa YY MM	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 31	Ttl.	days	days
Reiwa YY MM	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 31	Ttl.	days	days
Reiwa YY MM	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 31	Ttl.	days	days

Did you (will you) receive any wages for the above period?	☐ Yes ☐ No	Type of salary	☐ Monthly wage ☐ Hourly wage ☐ Daily wage ☐ Commission ☐ Daily-based monthly wage ☐ Others	Wage calculation	Closing date		day
					Date of payment	☐ Current month ☐ Next month	day

Enter the wages incurred in a wage calculation period including the above period.

Details of wages incurred (accrued)

Period / Category	Unit Price	For MM DD - MM DD	For MM DD - MM DD	For MM DD - MM DD
		Amount paid on MM DD	Amount paid on MM DD	Amount paid on MM DD
Base salary				
Commuting allowance				
Housing allowance				
Dependent allowance				
Overtime allowance				
Allowance				
Total				

Please enter the wage calculation method (e.g., method of calculating deductions for leave of absence).

If commuting allowance is paid for multiple months and is not deducted for leave of absence, for the purpose of calculating the deduction, fill in the relevant month even if it has already been paid.

yen for months

For MM - MM

Date of payment

Reiwa YY MM DD

I hereby certify that there is no discrepancy as described above.

Staff name	

Location of business office

Name of business office

Name of Employer 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.