Health Insurance Insured **Family** 

## **Medical Care Expenses Application Form**

(payment of full medical costs upfront without using health insurance, etc.)

To be filled out by the insured person (the applicant)

Please use double-sided printing to help simplify clerical duties.

⊋ ≣		Symbol		Numbe	er		Date of	Birth (MM. DD, Y	YYY)
Information i (Applicant)	Insurance c (Fill in from the side)		0 1	2	3 4 5	6	□ Showa  ☑ Heisei	0 1	1 1 2 0
ega		(Furigana)	ボッシュ	ケンポ					
regarding the insured person	Name	Bosch Kempo							
	Address	(₹ 35	Saitama 22 2-					5-5 Yakyu-cho, gashimatsuyama City	
ed bei	Telephone number (Daytime contac	TEL <b>049</b>							
9011	I delegate the authority to submit this application form to my employer (Place a check mark in the box to delegate authority)								ity)
Designated transfer account	Name of financ institution	<sup>ial</sup> Sait	ama Resona	Coopera	Bank Credit Shinkin Bank Agricultural Fishery Cooperative Cooperative			nima na	Main Branch Cocal office Head Office Office
	Account type	1. Oru 2. Cu	dinary 3. Special 4. Deposit at notice	Account numb	er 7 6	5 4 3 2	2 1	Fill in from the le	eft side.
er account	Account holde	1 %	ave one square between y	our first and last nam	e. Please write diacri	tic marks (", °) as o	ne character.)	Account holder category	1 1. Applicant 2. Agent
									1
	Ber		I delegate the authority to receive benefits based on this application form to  Date: Reiwa (Y)/ (M)/ (D) the following agent:						
	Beneficiary age	Insured person (Applicant)	Name					Same as the addre	ess under "Information n (Applicant)"
	agent field	Agent	(〒 - Address	)	TE	L ( )			Relationship between the Delegator and the Agent
		(Account holder)	(Furigana  Name	)					

## Applicant Entry Form" continues on page 2. >

(R2.12)Name of the social insurance Reception date stamp and labor consultant serving as the agent in submitting this

The personal information you provide here is collected by the Health Insurance Society in order to conduct business operations in a fair and equitable manner, and in accordance with the Health Insurance Act and related government notices. We do NOT use personal information or provide it to third parties for any other purpose. In addition, we may ask you about the information you have provided, and, if necessary, we may request that you submit evidentiary documents separately. For inquiries or requests for disclosure regarding the handling of your personal information, contact the Bosch Health Insurance Society General

form

Affairs Division at 0493-22-0890.
\*For details on the handling of personal information, also refer to the "Privacy Policy" on our website.

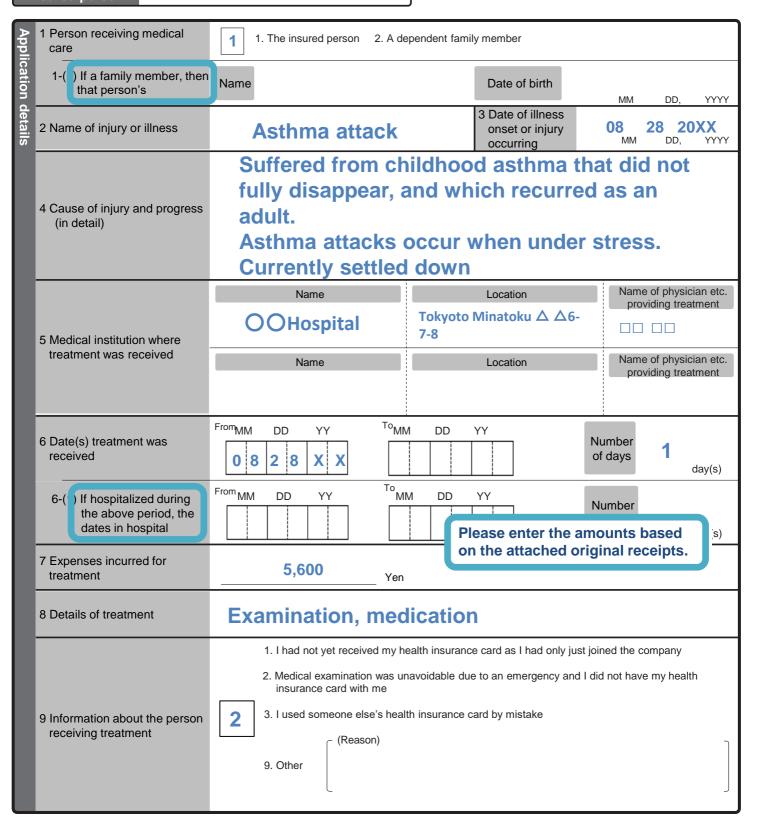
Health Insurance Insured Family

Medical Care
Expenses
Application Form

(payment of full medical costs upfront without using health insurance, etc.) To be filled out by the insured person (the applicant)

Name of the insured person

## **Kenpo BOSCH**



- lacktriangledown This application satisfies the conditions of (1) or (2). (Please check the box lacktriangledown.)
  - (1) This application was prepared by the insured person (the applicant him/herself).
  - (2) The applicant him/herself has checked that the content of the application is correct.