Health Insurance — Insured Family — Medical Care Expenses Application Form

(payment of full medical costs up-front without using health insurance, etc.)

1 | 2

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

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

Information regarding the insured person (Applicant)

	Symbol	Number	Date of Birth (MM. DD, YYYY)
Insurance card (Fill in from the right side)	1001	23456	☐ Showa ☑ Heisei 01 11 12 0

Name (Furigana): ボッシュ　ケンポ

Name: Bosch Kempo

Address: (〒 355 - 0028) Saitama 2-5-5 Yakyu-cho, Higashimatsuyama City

Telephone number (Daytime contact): TEL 0493 (22) 0890

☐ I delegate the authority to submit this application form to my employer (Place a check mark in the box to delegate authority)

Designated transfer account

Name of financial institution: Saitama Resona — (Bank) Credit Union Shinkin Bank Agricultural Cooperative Fishery Cooperative Other ( ) — Higashima tsuyama — Main branch (Branch) Local office Head office Branch office

Account type: 1 (1. Ordinary 2. Current 3. Special 4. Deposit at notice)

Account number: 7654321 (Fill in from the left side.)

▼Katakana (Leave one square between your first and last name. Please write diacritic marks (゛, ゜) as one character.)

Account holder: ホ゛ッシュ　ケンホ゜

Account holder category: 1 (1. Applicant 2. Agent)

Beneficiary agent field

Insured person (Applicant)

I delegate the authority to receive benefits based on this application form to the following agent:

Date: Reiwa (Y)/ (M)/ (D)

Name

Address: Same as the address under "Information regarding the insured person (Applicant)"

Agent (Account holder)

(〒 -) TEL ( )

Address

(Furigana)

Name

Relationship between the Delegator and the Agent

"Applicant Entry Form" continues on page 2. 〉〉〉

(R2.12)

Name of the social insurance and labor consultant serving as the agent in submitting this form	

Reception date stamp

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

Bosch Health Insurance Society
2-5-5 Yakyu-cho, Higashimatsuyama City, 355-0028 Internal mail: Hig RBHI

Health Insurance Insured / Family

Medical Care Expenses Application Form

(payment of full medical costs up-front without using health insurance, etc.)

1 | 2

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

Name of the insured person	Kenpo BOSCH

Application details

1 Person receiving medical care	1 (1. The insured person 2. A dependent family member)
1-(1) If a family member, then that person's	Name: / Date of birth: MM DD, YYYY
2 Name of injury or illness	Asthma attack
3 Date of illness onset or injury occurring	08 (MM) 28 (DD,) 20XX (YYYY)
4 Cause of injury and progress (in detail)	Suffered from childhood asthma that did not fully disappear, and which recurred as an adult. Asthma attacks occur when under stress. Currently settled down
5 Medical institution where treatment was received	Name: ○○Hospital / Location: Tokyoto Minatoku △ △6-7-8 / Name of physician etc. providing treatment: □□ □□
	Name: / Location: / Name of physician etc. providing treatment:
6 Date(s) treatment was received	From MM DD YY: 0 8 2 8 X X / To MM DD YY: / Number of days: 1 day(s)
6-(1) If hospitalized during the above period, the dates in hospital	From MM DD YY: / To MM DD YY: / Number: 's)
7 Expenses incurred for treatment	5,600 Yen
8 Details of treatment	Examination, medication
9 Information about the person receiving treatment	2 1. I had not yet received my health insurance card as I had only just joined the company 2. Medical examination was unavoidable due to an emergency and I did not have my health insurance card with me 3. I used someone else's health insurance card by mistake 9. Other (Reason)

Please enter the amounts based on the attached original receipts.

☑ This application satisfies the conditions of (1) or (2). (Please check the box ☑.)

(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.