# Health Insurance Insured Family Medical Care Expenses Application Form (Therapeutic Orthotic Devices)

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 |

(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.)

Account holder (▼Katakana (Leave one square between your first and last name. Please write diacritic marks (“, ゜) as one character.)): ﾎﾞｯｼｭ ｹﾝﾎﾟ

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:

Name

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

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 (Therapeutic Orthotic Devices)

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 | Flat feet (both feet) |
| 3 Date of illness onset or injury occurring | 09 16 20XX (MM DD, YYYY) |
| 4 Cause of injury and progress (in detail) | Heel pain from overloading due to obesity<br>Wearing the orthotic devices eliminates the pain.<br>Progress is good. |
| 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: 0 9 1 6 X X — Number of days: 3 day(s) |
| 6-(2) If hospitalized during the above period, the dates in hospital | From MM DD YY: — To MM DD YY: — Number of days: — day(s) |
| 7 Date instructed to wear the orthotics etc. | MM DD YY: 0 8 2 8 X X |
| 8 Date orthotics fitted | MM DD YY: 0 9 1 6 X X |
| 9 Expenses incurred for treatment | 25,000 Yen |
| 10 Details of treatment | Scan, medical examination, fitting of orthotic devices for both feet |
| 11 Reason for medical expenses application | 5 (5. Having therapeutic orthotic devices made) |

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.

# Orthotic Device Fabrication Confirmation Form (1)

To be submitted only for therapeutic orthotic devices

Response regarding fabrication of the orthotic devices applied for is necessary for the review and payment of benefits.

Submission of this form is not required for fabrication of prescription glasses and compression garments.

| Health insurance card | | Name of the insured person | Name of person to whom devices were fitted |
|---|---|---|---|
| Symbol | Number | | |
| 1001 | 23456 | Kenpo BOSCH | Kenpo BOSCH |
| Name of orthotic device made | | Date of fitting (date of purchase) | |
| Orthotic devices for both feet | | 09 (MM) 16 (DD,) 20XX (YYYY) | |

Please enter the appropriate number.

**Q1: Is this the first time you have had an orthotic device made for this injury or illness?**

[1]

1. First fabrication
2. Have had fabricated before; this is a new fabrication
3. Have had fabricated before; this involves repairs to an orthotic device still in use

Fill in if you selected 2 or 3

| Month and year of fabrication | Usage status | Month and year returned or disposed of |
|---|---|---|
| Around MM YYYY | [ ] 1. Still using it now 2. Returned it to the orthotic supplier 3. Disposed of it | Around MM YYYY |

**Q2. Do you have a disability passbook?**

We would like to check whether you have a disability certificate to determine if you are eligible for orthotic device expenses under the Act for the Comprehensive Support of Persons with Disabilities

[2]

1. I have one → Please attach a copy of your disability passbook
2. I do not have one

**Q3: How did you fit the size of the orthotic device you had made?**

[1]

1. Molding such as putting a plaster cast on the affected area and/or around it, or placing the foot on plaster
2. Taking detailed measurements of each part of the affected area and/or around it
3. Estimating the size with a tape measure to select a ready-made product from sizes such as S/M/L (only sizing was taken)
4. Took no action
5. Other →

Person who took the measurements: [3] 1. Physician 2. Nurse etc. 3. Orthotics supplier

Provide details here

# Orthotic Device Fabrication Confirmation Form (2) (for attaching photos)

How to take the photographs

(1) Please affix photographs (plain paper is acceptable) in the box below. Please attach photographs which cannot be affixed.

(2) Please take photos so that the entire orthotic device is visible.

(3) For orthotics that are inserted into shoes (such as insoles), please take them out of the shoes and photograph them from above.

(4) If there are any sizes or logos printed on the orthotics, please photograph those areas as well.

| (2) Please take photos so that the entire orthotic device is visible.<br>(3) For orthotics that are inserted into shoes (such as insoles), please take them out of the shoes and photograph them from above. |
| --- |
| |
| (4) If there are any sizes or logos printed on the orthotics, please photograph those areas as well. |
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