Health Insurance Overseas Medical Care Expenses Application Form

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 11 20 01

Name

(Furigana) ボッシュ　ケンポ

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: 7 6 5 4 3 2 1 (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゛	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 Overseas Medical Care Expenses Application Form

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 — 2 (1. The insured person 2. A dependent family member)

1-( ) If a family member, then that person's — Name: Mamoru BOSCH — Date of birth: 04 (MM) 05 (DD,) 2016 (YYYY)

2 Name of injury or illness: Left ankle sprain

3 Date of illness onset or injury occurring: 08 (MM) 28 (DD,) 20XX (YYYY)

4 Cause of injury and progress (in detail):

Twisted left ankle and fell over while coming off a slide at the park, spraining the ankle

Progress is good

5 Medical institution where treatment was received

Name	Location	Name of physician etc. providing treatment
Praxis Dr. ○○	70469 Stuttgart △△△	□□ □□

Name of country: Germany

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-( ) If hospitalized during the above period, the dates in hospital: From MM DD YY — To MM DD YY — Number ( )s)

Please enter the amounts based on the attached original receipts.

7 Expenses incurred for treatment: 150 (Euros) Please enter the currency (e.g. U.S. dollars).

8 Details of treatment: After examination, ointment was prescribed.

9 Information about the person receiving treatment

Are they currently planning to return to Japan? Or have they already returned?

☑ 1. Yes ☐ 2. No

Reasons for staying abroad [ ]

・Period of travel (August 22, 20XX to August 31, 20XX)
・Purpose of travel
Reasons for travel

[For travel]

☑ 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.