Health Overseas Medical Application Insurance **Care Expenses**

Form

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

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

(Ap	Info	Symbol		Number		Date o	f Birth (MM. DD, Y	YYY)	
(Applicant)	Insurance ca (Fill in from the ri side)		0 1	2	3 4 5 6	☐ Show	1 1 1 1	2 0 0 1	
Ċ		(Furigana)	ボッシュ	ケンポ					
raing th	Name	Bosch Kempo							
Information regarding the insured person (Applicant)	Address	(₹ 35	Saitama 2 2-				5-5 Yakyu-cho, gashimatsuyama City		
	Telephone number (Daytime conta	TEL 0493 (22) 0890				Tilgasiiii			
	☐ I delegate	the authority to	submit this application	n form to my emp	oloyei (Place a check m	ark in the box to	delegate authori	ty)	
Designate	Name of financinstitution	Saltama Resona (Continue) (Continue) (Continue)			Main Branch (Local office) Head Branch office				
ed transf	Account type 1 1. Ordinary 3. Special 4. Deposit at notice 7		7 6 5 4	3 2 1	Fill in from the le	ft side.			
Designated transfer account	Account holds	1 "	ave one square between y	bur first and last name.	Please write diacritic marks (", °) as one character.)	Account holder category	1. Applicant 2. Agent	
	Beneficiary age	Insured person (Applicant)	I delegate the authori the following agent: Name	ty to receive benefit	s based on this application f	Address:	Date: Reiwa (Y) Same as the addre	ss under "Information	
	/ agent field	Agent (Account holder)	(〒 - Address (Furigana))	TEL ()			Relationship between the Delegator and the Agent	
			Name		"Applican	t Entry For	n" continues	s on page 2. 〉〉	

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

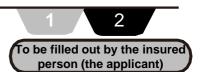
Reception date stamp

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.

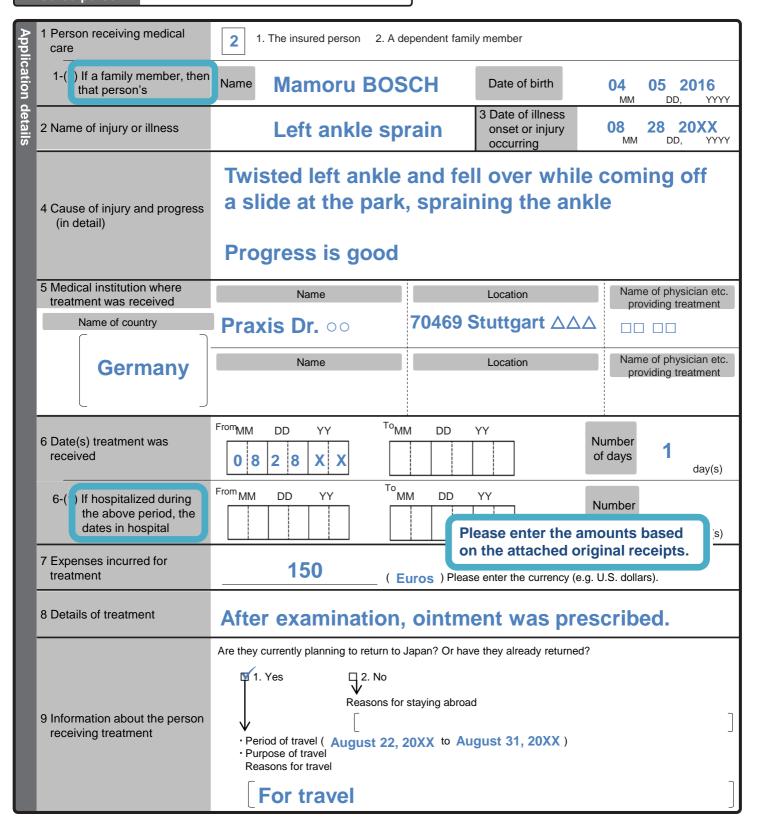
Health Overseas Medical Insurance Care Expenses

Application Form



Name of the insured person

Kenpo BOSCH



- \square This application satisfies the conditions of (1) or (2). (Please check the box \square .)
 - (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.