

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

Information regarding the insured person (Applicant)	Insurance card (Fill in from the right side)	Symbol 1 0 0 1	Number 2 3 4 5 6	Date of Birth (MMM. DD, YYYY) <input type="checkbox"/> Showa <input checked="" type="checkbox"/> Heisei 0 1 1 1 2 0
	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		
<input type="checkbox"/> I delegate the authority to submit this application form to my employee (Place a check mark in the box to delegate authority)				

Designated transfer account	Name of financial institution	Saitama Resona	<input checked="" type="radio"/> Bank <input type="radio"/> Credit Union <input type="radio"/> Shinkin Bank <input type="radio"/> Agricultural Cooperative <input type="radio"/> Fishery Cooperative <input type="radio"/> Other ()	Higashimatsuyama	<input checked="" type="radio"/> Main branch <input type="radio"/> Branch <input type="radio"/> Local office <input type="radio"/> Head office <input type="radio"/> 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

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)
	Agent (Account holder)	Name	Address: Same as the address under "Information regarding the insured person (Applicant)"	
		Address	(〒 -)	TEL ()
	(Furigana)			
	Name			

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

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

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.

Application details	1. Name of injury or illness	1) Clavicle fracture 2) 3)	2. Date of illness onset or injury	<input type="checkbox"/> Heisei <input checked="" type="checkbox"/> Reiwa X/12/ 1 <input type="checkbox"/> Heisei <input type="checkbox"/> Reiwa (Y) / (M) / (D) <input type="checkbox"/> Heisei <input type="checkbox"/> Reiwa (Y) / (M) / (D)
	3. Situation at the time of illness onset or injury for the relevant injury or illness	Tripped over a stone while walking on the sidewalk, and hit the ground from the right shoulder.		
	4. Period of absence for medical treatment (application period)	(<input type="checkbox"/> Heisei <input checked="" type="checkbox"/> Reiwa) (Y) / (M) / (D) From 0 X 1 2 0 1 To 0 X 0 1 1 5		Number of days 46 day(s)
	5. Your job description (in detail) (In the case you are applying after retirement, provide details on your job before retirement)	Do NOT describe the content of your work as "clerical worker." Instead provide specific details, such as "accounting affairs," "automobile assembly," or "programmer."		

Confirmation items	1. Did you receive wages during the period of absence for the above medical treatment (application period)? Or will you receive wages in the future?	2	1. Yes 2. No
	2. Are you receiving "Disability Employees' Pension" or "Disability Benefits"? If so, which one are you receiving?	3	1. Yes  <input type="checkbox"/> 1. Disability Employees' Pension 2. Pending <input type="checkbox"/> 2. Disability Benefits 3. No
	2-[1] If you answered "Yes" or "Pending," fill in the name of the injury or illness that was (will be) the cause for your claim and your Basic Pension Number. [If you answered "Pending," fill in the name of the injury or illness and your Basic Pension Number.]	Name of injury or illness ----- Basic Pension Number Pension Code ----- Date of initial payment <input type="checkbox"/> Showa <input type="checkbox"/> Heisei <input type="checkbox"/> Reiwa (Y) / (M) / (D) Benefit amount _____ yen	
	3. (Fill out this field if you have lost your eligibility for health insurance.) Are you receiving a public pension due to old age or retirement? If you are receiving a pension, fill in the name.	<input type="checkbox"/>	1. Yes  <input type="checkbox"/> Name 2. Pending 3. No
	3-[1] If you answered "Yes" or "Pending," fill in your Basic Pension Number. [If you answered "Pending," fill in the name of the injury or illness and your Basic Pension Number.]	Basic Pension Number Pension Code ----- Date of initial payment <input type="checkbox"/> Showa <input type="checkbox"/> Heisei <input type="checkbox"/> Reiwa (Y) / (M) / (D) Benefit amount _____ yen	
	4. Is this application for a period during which you received compensation for an absence from work through workers' compensation insurance? 4-[1] If you answered "Yes" or "Workers' compensation pending," fill in the Labor Standards Inspection Office through which payment is being received (or the claim was filed).	3	1. Yes 3. No 2. Workers' compensation pending Labor Standards Inspection Office

This notification satisfies the requirements of [1] and [2] below. (Place a check in the box)

[1] This form was prepared by the applicant (the insured person).

[2] The applicant has verified that there are NO errors in the information contained herein.

"Employer Entry Form" continues on page 3. > > >

Fill in the work status and wage payment status for the wage calculation period that includes the period the employee was unable to work.

Information to be certified by the employer

Name of insured person: **Bosch Kempo**

Indicate the work status using [O for attendance], [Δ for paid leave], [P for public holidays], and [/ for absence].

Reiwa X / 12	P Δ Δ Δ Δ Δ Δ P B 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total	0 Day	4 Day
Reiwa X / 1	P B B B B B B 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total	0 Day	0 Day
Reiwa (Y) / (M)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total	Day	Day

Did (or will) the employee accrue wages during the above period? Yes No

Wage type: Monthly Hourly Daily Commission Daily paid monthly Other

Wage calculation: Closing date: Last day of the month: 25 Day. Payment date: Current month Following month

Fill in the wage accrual status for the wage calculation period that includes the above period.

Period	Unit Price	From 12 / 1 to 12 / 31	From 1 / 1 to 1 / 15	From MMM.DD. to MMM. DD.	Fill in the wage calculation method (absence deduction calculation method, etc.)
		Amount paid for MMM. DD.	Amount paid for MMM. DD.	Amount paid for MMM. DD.	
Basic salary	200,000	40,000	0		Basic salary absence deduction 200,000 yen ÷ 20 days × 16 days = 160,000 yen No absence deduction for commuting allowance
Commuting allowance		0	0		
Housing allowance	15,000	15,000	15,000		If the deduction start date differs from the absence start date, please indicate that here. If commuting allowance is paid for multiple months at once and deductions are NOT made for absences, fill in the corresponding months even if already paid in order to calculate deductions.
Family allowance					
Overtime allowance		100,000			Overtime allowance for December is for overtime worked on 12/1 - 31.
Meal Allowance	6,000	0	0		60,000 yen for 6 month(s) From August to January
Total	281,000	155,000	15,000		Payment date: July 25

Breakdown of accrued (future) wages

Reiwa X / 1 / 31

Name of the responsible person: □ □ □ □

I certify that there are NO discrepancies in the information above.

Location of office: 1 -2 -3 ○○, Higashimatsuyama-city, Saitama
Name of office: ΔΔΔΔ Co., Ltd.
Name of employer: □□□□

Telephone: 049 (XXX) XXXX

If you wish to correct any information you have entered, cross out the information to be corrected with a double line, and fill in the correct information along with the name (signature) of the person who certified the changes.

Field for the person in charge of medical treatment to provide an opinion

Name of patient		Bosch Kempo			
Name of injury or illness	(1)	Clavicle fracture		Commencement date for medical treatment benefits	(1) <input type="checkbox"/> Heisei <input checked="" type="checkbox"/> Reiwa X / 12 / 1
	(2)			(Date of initial consultation)	(2) <input type="checkbox"/> Heisei <input type="checkbox"/> Reiwa (Y) / (M) / (D)
	(3)				(3) <input type="checkbox"/> Heisei <input type="checkbox"/> Reiwa (Y) / (M) / (D)
Date of illness onset or injury	Reiwa X / 12 / 1	<input checked="" type="checkbox"/> Illness onset <input type="checkbox"/> Injury	Cause of illness onset or injury Heavy blow to the right shoulder		
Period recognized as unable to work	Fill in the period and the number of days during which the employee was recognized as being unable to work due to medical treatment, NOT the treatment period. Also, fill in the period before the certification date.				
Length of hospital stay	From Reiwa (Y) / (M) / (D). To Reiwa (Y) / (M) / (D)	For day(s) Hospital stay	Other medical expenses	<input checked="" type="checkbox"/> Health insurance <input type="checkbox"/> Public funds () <input type="checkbox"/> Self-paid <input type="checkbox"/> Other	Outcome <input type="checkbox"/> Recovered <input type="checkbox"/> Discontinued <input checked="" type="checkbox"/> Carried forward <input type="checkbox"/> Hospital transfer
Actual days of medical care (including length of hospital stay)	5 Day	Circle the dates of medical examinations and hospitalization.	12 Month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 1 Month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
Provide details on the major symptoms, progress, treatments, test results, and medical care guidance, etc., during the above period.			Date of operation Reiwa (Y) / (M) / (D)		
<p>First visit on December 1st for a fractured collarbone. Set with a clavicle band. Rest until the bone sets, and rehabilitation afterwards.</p>			Date of discharge Reiwa (Y) / (M) / (D)		
Based on the course of symptoms, describe any medical findings indicating that the patient was unable to engage in his/her regular occupation.					
It was judged that the employee was unable to work due to the need for rest until the fractured bone set and to the need for rehabilitation thereafter.					
When dialysis is performed or an artificial organ is attached	Date dialysis was performed or an artificial organ was attached	<input type="checkbox"/> Showa <input type="checkbox"/> Heisei <input type="checkbox"/> Reiwa (Y) / (M) / (D)	Type of artificial organ, etc.	<input type="checkbox"/> Colostomy <input type="checkbox"/> Prosthetic joint <input type="checkbox"/> Head prosthesis <input type="checkbox"/> Cardiac pacemaker <input type="checkbox"/> Kidney dialysis <input type="checkbox"/> Others ()	
Reiwa X / 1 / 22					
There are no discrepancies in the above information.					
Location of the medical institution	1 -2 -3, OO, Moroyama-machi, Iruma-gun, Saitama				
Name of the medical institution	△△△△ General Hospital				
Name of the doctor	□□□□				Telephone 049 (XXX) XXXX

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