Health Insurance Supplemental Injury and Sickness Benefits [Extension] Payment Application Form

1 2 3 4

Applicant Entry Form

Information regarding the insured person (Applicant)

	Symbol	Number	Date of Birth (MMM. DD, YYYY)
Insurance card (Fill in from the right side)			☐ Showa ☐ Heisei
Name	(Furigana)		
Address	(〒 -)		
Telephone number (Daytime contact)	TEL ( )		

☐ 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	Bank / Credit Union / Shinkin Bank / Agricultural Cooperative / Fishery Cooperative / Other ( )		Main branch / Branch / Local office / Head office / Branch office
Account type	1. Ordinary 2. Current 3. Special 4. Deposit at notice	Account number	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.)	Account holder category	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

◆ After applying for "Disability employees' Pension" or "Disability Benefits" and receiving the "Pension Certificate" or "Notification of Pension Decision," send a copy to Bosch Health Insurance Society without delay.

(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.

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

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Applicant Entry Form

Application details

1. Name of injury or illness	1)	2. Date of illness onset or injury	☐ Heisei ☐ Reiwa (Y) / (M) / (D)
	2)		☐ Heisei ☐ Reiwa (Y) / (M) / (D)
	3)		☐ Heisei ☐ Reiwa (Y) / (M) / (D)
3. Situation at the time of illness onset or injury for the relevant injury or illness			
4. Period of absence for medical treatment (application period)	(☐ Heisei ☐ Reiwa) (Y)/ (M)/ (D) From To	Number of days	day(s)
5. Your job description (in detail) (In the case you are applying after retirement, provide details on your job before retirement)			

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?
☐ 1. Yes
2. No

2. Are you receiving "Disability Employees' Pension" or "Disability Benefits"?
If so, which one are you receiving?
☐ 1. Yes
2. Pending
3. No
→ ☐ 1. Disability Employees' Pension
2. Disability Benefits

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 ☐ Showa ☐ Heisei ☐ 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.
☐ 1. Yes
2. Pending
3. No
→ Name

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 ☐ Showa ☐ Heisei ☐ 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?
☐ 1. Yes 3. No
2. Workers' compensation pending

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).
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. 〉〉〉

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Employer Entry Form

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	

Indicate the work status using [○ for attendance], [△ for paid leave], [P for public holidays], and [/ for absence].			Attendance	Paid leave
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
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
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	Day
					Payment date	☐ Current month ☐ Following month Day

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

Breakdown of accrued (future) wages

Period / Category	Unit Price	From MMM.DD. to MMM. DD.	From MMM.DD. to MMM. DD.	From MMM.DD. to MMM. DD.
		Amount paid for MMM. DD.	Amount paid for MMM. DD.	Amount paid for MMM. DD.
Basic salary				
Commuting allowance				
Housing allowance				
Family allowance				
Overtime allowance				
Allowance				
Total				

Fill in the wage calculation method (absence deduction calculation method, etc.)

Reiwa (Y)/ (M)/ (D)

Name of the responsible person	

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

Location of office

Name of office

Name of employer

Telephone ( )

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.

"Medical Staff Entry Form" continues on page 4. 〉〉〉

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Medical Staff Entry Form

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

Name of patient			
Name of injury or illness	(1) (2) (3)	Commencement date for medical treatment benefits (Date of initial consultation)	(1) ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D) (2) ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D) (3) ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D)
Date of illness onset or injury	☐ Heisei ☐ Reiwa (Y)/ (M)/ (D) ☐ Illness onset ☐ Injury	Cause of illness onset or injury	
Period recognized as unable to work	From ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D) To ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D) For day(s)		
Length of hospital stay	From ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D) For day(s) To ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D) Hospital stay	Other medical expenses	☐ Health insurance ☐ Public funds ( ) ☐ Self-paid ☐ Other Outcome ☐ Recovered ☐ Discontinued ☐ Carried forward ☐ Hospital transfer

Actual days of medical care (including length of hospital stay)	Day	Circle the dates of medical examinations and hospitalization.	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 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
☐ Heisei ☐ Reiwa (Y)/ (M)/ (D)

Date of discharge
☐ Heisei ☐ 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.

When dialysis is performed or an artificial organ is attached	Date dialysis was performed or an artificial organ was attached	☐ Showa ☐ Heisei ☐ Reiwa (Y)/ (M)/ (D)	Type of artificial organ, etc. ☐ Colostomy ☐ Prosthetic joint ☐ Head prosthesis ☐ Cardiac pacemaker ☐ Kidney dialysis ☐ Others ( )

Reiwa (Y)/ (M)/ (D)

There are no discrepancies in the above information.

Location of the medical institution

Name of the medical institution

Name of the doctor

Telephone ( )

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.