Managing director	Clerical supervisor		Person in charge

Health Insurance Notification of Change of Covered Dependents (Removal)

Attachment Document (1): Please attach the insurance qualification certificate of the dependent to be deleted.
Attachment Document (2): To delete a dependent due to the start of receiving employment insurance, please attach a copy of the employment insurance benefit qualification certificate which lists the start date of receiving employment insurance.
***Please fill in the form in Japanese.**

Submission date:	Reiwa (Y) / (M) / (D)

Section for insured person					
Insurance Person Code		Insurance Person Number		Date of birth	Showa/Heisei (Year)/(Month)/(Day) / /
Employee ID				Address	Postal code
Name	(Furigana)	(Furigana)			
	(Last name)	(First name)			Telephone number – –

Section for confirming insured person	☐ I wish to issue a certificate of losing qualification
⇒ Mailing address for certificate of losing qualification to be sent (not required when the same as the address of the insured person)	Postal code

Section for dependent						
Name	(Furigana)	(Furigana)	Date of birth	Showa/Heisei/Reiwa (Year)/(Month)/(Day) / /	Gender	1. Male 2. Female
	(Last name)	(First name)				
Relationship		Date of removal as a dependent	Reiwa (Y) / (M) / (D)	Reason		

Section for dependent						
Name	(Furigana)	(Furigana)	Date of birth	Showa/Heisei/Reiwa (Year)/(Month)/(Day) / /	Gender	1. Male 2. Female
	(Last name)	(First name)				
Relationship		Date of removal as a dependent	Reiwa (Y) / (M) / (D)	Reason		

Section for dependent						
Name	(Furigana)	(Furigana)	Date of birth	Showa/Heisei/Reiwa (Year)/(Month)/(Day) / /	Gender	1. Male 2. Female
	(Last name)	(First name)				
Relationship		Date of removal as a dependent	Reiwa (Y) / (M) / (D)	Reason		

Date request received (stamp)

Office address	Postal code
Name of office	
Name of employer	
Telephone number	( )

Labor and social security attorney submitting the application on behalf of the insured

Salesforce Health Insurance Association