Health Insurance Dependent Status Report
Written Oath

I hereby	hereby certify that the information listed below is true and correct. If there are any discrepancies with the facts, to do not object to the cancellation of certification or the refund of the benefits paid by the health insurance Association.																				
Also, if I obtain employment or if my income fluctuates, I will promptly engage in procedures for removing dependents. To the Executive Head of the Salesforce Health Insurance Association																					
Date:			(Y) 6 / (M) 4			ice Association Name of insured person								健保 太郎							
 Please enter the required information or circle the applicable items for the certified person. Please fill in the form in Japanese. 																					
■ PI	ease fill i	in the	e form in Japan	ese.		Nama	of cortified no	urcon.	/mb /1	健保 花子									·		
Insur	10.0	ode	2000	Num	0000	Name of certified person			19里17	₹ 1 1	167		Relat	tionship		F	Age	30)歳		
Per	son			ber	*16	newborn b	ridual numb aby and personal numb or determined, it can	ımber has 1	1	1	1	1	1	1	1	1	1	1	1		
		*H	ave vou re	egist	ered to use the				d? (ch	eck	one	or the	e oth	er)	Ye	25	No		1		
					Please fill in this section only if the person applying for being a dependent is a child.																
				If t	he person applying for b				-	-				s form.							
Is your spouse already a member of our Yes																					
			rance plan?		NO Last years's income (yen/year) Current income (yen/year) %including pension income													me			
					1. Obtained employr	nent a	at compan	V													
				2. Got married Date of marriage Reiwa (Y) / (M) / (D)											D)						
(1)	Reaso	Reason why application as a			3. Quit work and lost all income Date of retirement Reiwa (Y) / (M) / (D										D)						
	dependent was made			4. Income decreased Reiwa (Y) / (M) / (D)												D)					
				5. Completed receip	5. Completed receipt of employment insurance benefits Completed receipt Reiwa (Y) / (M) / (D)												D)				
					6. Other []							
(2)	Please list the health				National Health Insurance																
	insuran current		ı which you aı vrolled	re	3. Other health ins		•						ccociat	l noi:	セクロ	∠ 1∓°	由古士:	±Γ 1			
/- \					*If you circled 1., 2., or 3. above, please enter the name of your health insurance Association [協会けんぽ 東京支部 Yes									ab]							
(3)	Are you currently working?				(Go to (7))							(Go to (4))									
(4)	1) Did you work during the past year?				Yes (Go to (5))										No Go to (
(5)	Were you enrolled in				Yes (Go to (6)) No (Go to (7))																
(5)	employr	ment	insurance?		[Reason for retirement:]																
	Please list the current status of employment insurance receipt.			1. Currently receiving pension [Daily amount] ¥ 2. Currently applying or planning to apply [Date of proodures] (V)/(M)/(D)																	
				2. Currently applying or planning to apply [Date of procedures] (Y)/(M)/(D)																	
(6)		*If the basic daily amount exceeds 3,612 yen, certification is not possible (5,000 yen for those over 60 years old)			Currently extending or planning to extend [Reason for extension] Completed receipt																
					4. Completed receipt 5. Will not receive [Reason:]																
					6. Other [] (Go to (7))																
(7)) Do you currently have income?				Yes							No									
(,,	Please list your current amount of				(Go to (8))							(Go to (10))									
(8)	income.				[Annual income: approx.							yen] (Go to (9))									
(9)					1. Salary (part-tim							2. Real estate income									
					3. Interest/dividend income 4. Self-employed income																
					5. Pensions (please circle the type) A. Old age pension B. Survivor's pension C. Personal pension D. Disability pension																
			ne details of y	our	E. Corporate pension F. Onkyu pension G. Other []																
	income.				6. Social insurance benefits (please circle the type)																
					A. Injury and illness allowance B. Maternity allowance																
					C. Work leave compensation, etc., from industrial accident compensation insurance D. Other []																
					7. Other [] (Go to (10))																
(10)											on for living separately [
	Do you live with the insured			Yes					Reason for living separately [] Amount transferred in one month [yen]												
	person?				<i>F</i>						reason for separation is other than single residence or school										
					a such as a such		9 10	(-4h · · · · ·			atte	ndance,	please	e attach	proof o	f remitt	ance.				
■ If y					r such as parents, paren	spouse/ch	ouse/children living together), please complete the following section. Yes [Name of spouse:]							ion.							
(11)	have a		ertified pers ouse?	OII	1. Separation due to dea		[Annual income of spouse: yen]						1								
(12)	■ Please fill in the family structure of the certified person.				Name		Relationship	Age	House	hold	_	nual inc				tified pe			ny aid?		
								Cohabit /				yer	_	es [n] / I				
								Cohabit /	Separate			yer	n Y	es [ye	n] / I	No			
	per 3011.								Cohabit /	Separate			yer	n Y	es [ye	n] / [No		

Salesforce Health Insurance Association

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I hereby certify that the information listed below is true and correct. If there are any discrepancies with the facts, I do not object to the cancellation of certification or the refund of the benefits paid by the health insurance Association.

Also, if I obtain employment or if my income fluctuates, I will promptly engage in procedures for removing dependents.

To the Executive Head of the Salesforce Health Insurance Association

Date		(Y) 6 / (M)		on or circle the applica	hle itam	s for the cor	tified nerco	Name of insu	red pers	ıυn								
		e form in Japa		on or circle the applica	able Item	is for the cer	tified persoi	1.										
	rance rson	2000	Num ber	0000		of certified pe		健保	一郎		Relatio	onship	長男	Age	C	歳		
rei	3011		bei			vidual numb baby and personal nu												
	*F	łave you r	egist	ered to use the	e MYN	NA insur	ance car	d? (chec	k one	or th	e othe	er)	Yes	No				
			If t	Please fill in this he person applying fo								form.						
s your spouse already a member of our			of our	Yes														
•		urance plan?		No		Last year	s's income (У	en/year)	Current in	come (yen/year)	including per	nsion inco	me		
				1. Obtained employment at company														
				2. Got marriage Reiwa (Y) / (M) / (D)														
	Reason w	hy application	n as a	3. Quit work and lost all income Date of retirement Reiwa (Y) / (M) / (D)														
1)		dent was mad		4. Income decreased Reiwa (Y) / (M) / (D)											D)			
				5. Completed rece	eipt of e	mployment	insurance	benefits	Cor	npleted	receipt	Reiwa	(Y)	/ (M)	/(D)		
				5. Completed receipt of employment insurance benefits Completed receipt Reiwa (Y) / (M) / (D) 6. Other [
	Please list t	he health		National Health Insurance 2. Health insurance provided by employer														
(2)		n which you a	are	Other health insurance/mutual aid association 4. Not enrolled														
	currently e	nrolled		*If you circled 1., 2	2., or 3.	above, ple	ase enter t	ne name of	your h	ealth ins	urance /	Associa	ation []			
3)	Are you curr	ently working?	,			Yes (Go to (7))		No (Goto (A))										
	Did vou wor	k during the pa	ıst			(Go to (4)) No												
4)	year?				(Go to (7))													
5)	Were you er employment			[2	1	No (Go to (7))												
_	employmen	insurancer		[Reason for retirement:] 1. Currently receiving pension [Daily amount] ¥														
	Please list the current status of employment insurance																	
6)	receipt.			3. Currently extending or planning to extend [Reason for extension														
		aily amount exce	4. Completed receipt															
		tification is not p those over 60 ye		5. Will not receive]												
				6. Other [] (Go to (7))													
(7)	Do you curre	ently have inco	me?						(G	No o to (10))								
(8)		our current am	ount of		OX.	yen] (Go to (9))												
,,,	income.			1. Salary (part-ti			-		te incon	ne								
				3. Interest/divid														
				Interest/dividend income 4. Self-employed income Densions (please circle the type)														
(9)				A. Old age pension B. Survivor's pension C. Personal pension D. Disability pension														
		he details of	your	E. Corporate pension F. Onkyu pension G. Other []														
	income.			6. Social insurance benefits (please circle the type)														
				A. Injury and illness allowance B. Maternity allowance														
				7. Other [•				-		1	(Go t	o (10))					
(10)				-						No								
	Da !	o with the			Re	Reason for living separately [
	Do you live with the insured person?			Yes					Amount transferred in one month [yen]									
		person:		%If th					If the reason for separation is other than single residence or school									
				r such as parents, parents-in-law, siblings (other than spouse/childre						attendance, please attach proof of remittance.								
l If y				r such as parents, par	spouse/child	spouse/children living together), please complete the following section. Yes [Name of spouse:]												
11)	Does the o	certified per	rson	1.6											1			
	nave a spo	Juse!						1111111111	-									
	■ Please	fill in the fa	mily	Name		Relationship	Age	Househol Cohabit / Sepa	-	annual inc								
12)	structure	of the certif	ied		+			Cohabit / Sepa	_		yen		25 [en] /			
	person.							consuit / sepa	ute		yen	16	es [y ·	en] /	INO		

Yes [

yen] / No

Salesforce Health Insurance Association