Health Insurance Claim for Injury and Illness Allowance

***Please fill in the form in Japanese.**

Information on insured person

Insurance code and number	Code	Number	Name of affiliated office	
Name	Furigana		Date of birth	Heisei/Reiwa （Y） / （M） / （D）
				Heisei/Reiwa / /
Address, telephone number, etc. of applicant (daytime phone number)	Postal code			
				Phone number ( )
Employee ID			E-mail address	

Application details

Name of injury / illness	1)		Date of injury or onset of illness	Heisei/Reiwa （Y） / （M） / （D）
	2)			Heisei/Reiwa （Y） / （M） / （D）
	3)			Heisei/Reiwa （Y） / （M） / （D）
Cause of injury or illness				
Was it caused by the actions of a third party?	Yes ・ No	Please describe the situation if your medical care was required due to the actions of a third party.		
Period taken off due to injury/illness	Reiwa （Y） / （M） / （D） to Reiwa（Y） /（M） /（D） days			
Did you receive remuneration during the period taken off due to injury/illness? Will you receive remuneration in the future?			To present	Have received / Have not received
			In the future	Will be able to receive / Will not be able to receive
■ If you selected 'Have received' or 'Will be able to receive' above, please provide the remuneration payment period and amount below.				
Remuneration payment period	Reiwa （Y） / （M） / （D） to Reiwa（Y） /（M） /（D） days			
Amount of remuneration received	yen		Amount of remuneration that will be received	yen
■ Are you currently receiving or requesting disability pension/disability allowance, old-age pension, etc.?				Currently receiving / Currently requesting / Neither
If you answered “Currently receiving” or “Currently requesting,” please complete the following section.				
Type of pension, etc.	1. Disability pension 2. Disability allowance 3. Old-age pension 4. Other ( )			
Name of injury / illness			Pension amount	
Basic pension number			Date on which payment commenced	Reiwa（Y） /（M） /（D）
■ Are you currently receiving or requesting temporary disability compensation under Industrial Accident Compensation Insurance?				Yes / No
If you answered “Yes,” please list the Labor Standards Inspection Office of the payee (entity to which request for compensation was submitted).				Labor Standards Inspection Office

※Only fill out the following if you wish to transfer funds to another account other than your payroll account

Information on transfer destination

Name of financial institution		Bank / Shinkin bank (credit treasury)		Central branch / Branch	Branch number	
Type of account	Savings account / Checking account	Account number		Name of account holder (Katakana)		

Remarks

Individual number (not required when entering insured code and number)	
*If you entered your individual number, please attach the following documents to confirm your individual number and identity. One of the following: (1) Copy of individual number notification card, (2) Copy of certificate of residence listing individual number, (3) Copy of individual number card (both sides) ・When attaching (1) or (2) above, also attach one of the following: copy of driver’s license or copy of passport	

Date request received (stamp)

■Please obtain an opinion and certification from the attending physician.

Opinion of the doctor in charge of treatment

Patient Name			Date of illness or injury	(Y) /(M) /(D)	
Name of injury or illness	1)		Date treatment began	(Y) /(M) /(D)	
	2)			(Y) /(M) /(D)	
	3)			(Y) /(M) /(D)	
Cause of illness or injury					
Period deemed as incapacity for work	(Y) /(M) /(D) to (Y) /(M) /(D)	days	Actual Treatment Days		days
If hospitalized, duration of hospitalization	(Y) /(M) /(D) to (Y) /(M) /(D)	days			
Principal symptoms of the injury or illness, outline of the course of treatment, etc.					
Medical findings that indicate inability to work in the previous occupation based on the progression of symptoms					

I certify that the above is true and correct.

(Y) /(M) /(D)

Location of medical institution

Name of medical institution

Name of Doctor

■ Please obtain a certificate from your employer.

事業主証明欄

被保険者氏名						
勤務状況 【出勤は○】・【有給は△】・【公休は公】・【欠勤は／】でそれぞれ表示してください。					出勤	有給
令和 年 月	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				日	日
令和 年 月	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				日	日
令和 年 月	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				日	日
上記の期間に対して賃金を支給しました(します)か	はい ・ いいえ		賃金計算	締日	日	
給与の種類	月給 日給 時間給 歩合給 その他( )			支払日	□当月 □翌月 日	
上記の期間中にかかる分として支払った報酬(給与・賃金等)	支給期間		支給額		支払日	
	年 月 日 ～ 年 月 日			円	月 日	
	年 月 日 ～ 年 月 日			円	月 日	
	年 月 日 ～ 年 月 日			円	月 日	
現在まで、または将来も支給しない場合はその理由						
賃金計算方法(欠勤控除等)						

上記のとおり相違ないことを証明します。

令和 年 月 日

事業所所在地

事業所名称

事業主氏名

【事業主の方へ】

●労務に服さなかった期間を含む賃金計算期間の勤務状況および賃金支払状況等をご記入ください。

●勤務状況は出勤簿の写しの添付があれば記入は不要です。

●賃金台帳の写しを添付してください。

社会保険労務士の提出代行欄