

Health Insurance Claim for Injury and Illness Allowance

*Please fill in the form in Japanese.

Information on insured person	Insurance code and number	Code 2000	Number 0000	Name of affiliated office 株式会社 セールスフォース・ジャパン
	Name	Furigana ケンボ タロウ 健保 太郎		Date of birth Showa (Year) / (Month) / (Day) 54/6/19
	Address, telephone number, etc. of applicant (daytime phone number)	Postal code 123-4567 東京都〇〇区〇〇町1-2-3 △△マンション456号室 Phone number 090 (▲▲▲▲) 〇〇〇〇		
	Employee ID	××××		E-mail address XXXX@XXXX.ne.jp

Application details	Name of injury / illness	1) 右大腿部骨折	Date of injury or onset of illness	Reiwa 5/4/30	
		2)		Heisei/Reiwa (Y) / (M) / (D)	
		3)		Heisei/Reiwa (Y) / (M) / (D)	
	Cause of injury or illness	自宅の階段で足を踏み外し落下したため			
	Was it caused by the actions of a third party?	Yes <input type="radio"/> No <input checked="" type="radio"/>	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 5/5/1 to Reiwa 5/5/31 31 days			
	Did you receive remuneration during the period taken off due to injury/illness?	To present		Have received / Have not received	
	Will you receive remuneration in the future?	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 5/5/1 to Reiwa 5/5/31 31 days			
	Amount of remuneration received	10,000 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 <input checked="" type="radio"/> Currently requesting / Neither <input type="radio"/>	
	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 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.

療養担当医師の意見	患者氏名		発病または 負傷年月日	平・令	年	月	日
	傷病名	1)	療養を開始 した年月日	平・令	年	月	日
		2)		平・令	年	月	日
	発病または 負傷の原因	年 月 日					
	労務不能と 認めた期間	日間 診療実日数 日					
	入院した場合 はその期間	日 まで 日間					
	傷病の主たる症状 治療内容等						
	症状経過からみて 労務不能と認められ						
上記のとおり相 令和 年	医師の氏名						

Please ask the attending physician
to complete this section

■ Please obtain a certificate from your employer.

事業主証明欄	被保険者氏名										
	勤務状況	い。									
	令和 年	26	27	28	29	30	31	出勤	有給		
	令和 年	26	27	28	29	30	31	日	日		
	令和 年	26	27	28	29	30	31	日	日		
	上記の期間	締日						日			
	給与の種	算	支払日		□当月		日				
				□翌月							
	上記の期間 かかる分と 支払った額 (給与・賃金)	支給額		支払日							
	現在まで、ま 将来も支給し 場合はその	円		月		日					
賃金計算方 (欠勤控除)	円		月		日						
上記のとおり	円		月		日						
令和 年 月 日	事業所名称										
	事業主氏名										

Please ask the employer for a
certificate for this section

【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