Health Insurance Insured Person / Dependent Lump-sum Childbirth Allowance

(To be used to submit a proxy)

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

Information on insured person	Insurance Code and Number	Code	Number	Company Name	
	Full Name	Furigana		Date of Birth	Showa / Heisei (Year) / (Month) / (Day) / /
	Address, telephone number, etc. (daytime phone number)	Postal code		Phone number ( )	
	E-mail				

Application details	Person expected to give birth (circle the applicable person)	Insured person / Family member (dependent)	Name of person expected to give birth	
	Due date and expected number of babies	Reiwa (Y) /(M) /(D) Single birth Multiple birth (babies)	Date of birth for person expected to give birth	Showa / Heisei (Year) / (Month) / (Day) / /
	Name of hospital where delivery is expected		Address of hospital where delivery is expected	
	■ Complete the section to the right only if the following is applicable 1. If the insured person gave birth within six months after termination → Name, code and number, etc., of the insured person who is currently enrolled 2. Childbirth and childcare by dependent within 6 months after qualification→ Name, code and number, etc., of the insured person who was previously enrolled		Name of Insured Person	
			Phone Number	( )
			Code / Number	

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

Bank Transfer	Bank Code		Branch Code		
	Bank Name	Bank / Credit Union			Main Branch / Branch
	Account Type	Savings Other Checking ( )	Account Number	Name of Account Holder (Katakana)	

Remarks	■ This claim form will only be accepted two months before the expected date of delivery. ■ Please attach a copy of the page in the mother-child handbook that shows the expected date of birth or any document certifying the expected date of birth.

受取代理人の欄

申請者(　　)(以下「甲」という。)は、医療機関等である(　　)(以下「乙」という。)を代理人と定め、次の権限を委任します。また、甲は、出産育児一時金等の医療機関等への直接支払制度は利用しません。甲が請求する出産育児一時金等のうち、乙が甲に対して出産に関し請求する費用の額※の受領に関すること。

※出産育児一時金等の支給額(保険者が出産育児一時金等に係る付加給付を行う場合には付加相当額を含む)を上限とする。

令和　　年　　月　　日

甲(被保険者)　住 所

氏 名

乙(医療機関等)　所在地

名 称

受取代理人に対する支払金融機関					
金融機関名称	銀　行 / 信用金庫	本店 / 支店	預金種別	普通 ・ 当座 その他( )	
口座番号		口座名義(カタカナ)			

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)

Salesforce Health Insurance Association