

# Response Form for Previously Affiliated Health Insurance Enrollment Status

- Please complete the sections inside of bold lines.
- We will make inquiries to your previous health insurance associations. Please list all relevant information for the past year.  
If there is not enough space even when using the additional form, please make another copy of this form.
- If you belonged to the Japan National Health Insurance Association, you must enter the company name and basic pension number of your previous employer.  
(If the required information is not listed, we will contact you for confirmation.)
- Please fill in the form in Japanese.

Name	
Date of birth	Showa /Heisei (Year) / (Month) / (Day)
Address	
Daytime telephone number	

- Please fill out information for the mandatory fields and other applicable sections.

<input type="checkbox"/> More than 1 year has passed since enrolling at this health insurance association (Enrollment Date: (Y) / (M) / (D))
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Name of previous health insurance association	1. Health insurance association [ ] Health insurance association/branch
	2. Japan Health Insurance Association (enter the name of your previous employer and basic pension number (mandatory))
	3. National Health Insurance 4. Other [ ]
Company name of previous employer	
A: Pension Number	
Type	Insured person / Dependent
Period Insured	Date: Showa/Heisei/Reiwa (Y) / (M) / (D) to: Showa/Heisei/Reiwa (Y) / (M) / (D)

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	3. National Health Insurance 4. Other [ ]
Company name of previous employer	
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Type	Insured person / Dependent
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Company name of previous employer	
A: Pension Number	
Type	Insured person / Dependent
Period Insured	Date: Showa/Heisei/Reiwa (Y) / (M) / (D) to: Showa/Heisei/Reiwa (Y) / (M) / (D)