健康保険限度額適用認定申請書

*All the years should be written in the Japanese Calendar system.

•Application in advance is required for issuance of a certificate.
•If you pay high medical costs without applying in advance, the Health Insurance Society will automatically pay the amount over the copayment limit after about three months (no application required), therefore the final copayment amount will be the same.

資生堂健康保険組合 理事

Health Insurance Card [Number]
Employee Number
Company Name (Place of Employment)
Health Insurance Card [Symbol]

記号 ○○○○ 番号 ○○○○○○ 社員番号 ○○○○ 勤務先 ○○○○

Name of Insured Person (Name of Employee) → 花椿　太郎

Date of Birth: [Showa] / [Heisei] [Year][Month][Date]

◉昭和 ○平成 ○○ 年 ○ 月 ○ 日

Postal Code → 〒000 － 0000

Address of Insured Person → ○○○ ○○○○ ○○○ ○○－○

Phone Number (Daytime Contact) → 000-0000-0000

Relationship to Insured Person → 妻

Date of Birth: [Showa] / [Heisei] / [Reiwa] [Year][Month][Date]

Name of Eligible Person (A person who uses the certificate) → 花椿　花子

○平成 ◉令和 ○○年 ○ 月 ○ 日

The period of use of the certificate **(maximum 1 year)**

Please fill in the expected end date of the high medical expenses (within one year from the month of application). In accordance with the notification of the MHLW, the application cannot be made retroactively before the month in which the application form arrives at the Health Insurance Society.

From '1st of the month in which the application arrives' To 'Reiwa [Year] [Month]' → ～ 令和 ○ 年 ○ 月 まで

Was the Injury or Illness caused by work-related accident, commuting accident or a third-party act?: [Yes] / [No] → ◉いいえ

If "Yes", the cause was relevant to: [at work] / [on the way to work] / [traffic accident] ([with other party] / [without other party]) / [other (Detail)] → 他（　　）

Municipal Inhabitant Tax of Insured Person

◉市区町村民税 **Taxation**

○市区町村民税 **Non-taxation**
*If the Insured Person is exempt from Municipal Inhabitant Tax, attach the "Certificate of Exemption from Municipal Inhabitant Tax of the Insured Person".

Desired Delivery Address

*Please fill in the blanks and tick off appropriate reason if the Desired Delivery Address is not the Insured Person's address.

住所：〒 → Desired Delivery Address (with Postal Code)

宛名： → Addressee

電話番号： → Phone Number

上記以外に送付希望の場合のみ記入してください

Reason for change of Delivery Address: [The Insured Person is hospitalised] / [Other (Detail)]

送付変更理由 ○被保険者本人が入院中のため ○その他 （　　）

Section for Proxy Application

*Please fill in if the application is to be made by someone other than Insured Person due to Insured Person's hospitalisation etc.

被保険者が入院中等により被保険者以外の方が申請する場合は、ご記入ください。

氏　名 → Name of Proxy

電話番号 → Phone Number

Relationship to Insured Person (e.g. family relation, person in charge of the business office, etc.)

（例）家族、事業所担当者など

備考欄

I apply for the issuance of a Maximum Copayment Certificate for Health Insurance as described above.: Reiwa [Year] [Month] [Date]

上記のとおり健康保険限度額適用認定証の交付を申請します。令和 ○ 年 ○ 月 ○ 日

Note:
Please present the issued certificate together with the Health Insurance Card at the reception of the medical institution.
Please return the expired certificate as soon as possible.

How to apply:
Fill in the required information and submit the application.

＜申請方法＞
必要事項をご記入のうえ申請してください。

付印

【資生堂健康保険組合 2022. 12】

Internal