記入見本

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

This 'Loss of Entitlement' application form is to be submitted in the event of re-employment and enrolling another Health Insurance Society(Association), or in the event of loss of entitlement to insured status due to death of the Insured Person. (The Entitlement cannot be lost during the insurance period except in the case of re-employment or death.)
This application is not necessary in the case of expiration of Voluntarily Continued Insurance period (2 years after enrollment).

任意継続被保険者制度資格喪失届出書

Symbol of Health Insurance Card

[Number] of Health Insurance Card

Date of Submission: Reiwa[Year] [Month] [Date]

申請日　令和　○　年　○　月　○　日

記　号	番　号（5桁）	被保険者氏名
９９	○ ○ ○ ○ ○	花椿　太郎

Name of Insured Person

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

生年月日	○昭和 ●平成	○ 年	○ 月	○ 日

Reason of Loss of Entitlement

Please put ●in the appropriate tick box

資格喪失事由

該当番号を●で選択してください

●1. 任

[1. Due to re-employment and enrollment for another Health Insurance]

Please attach a copy of the newly-enrolled Insurance Card and the Shiseido Health Insurance Society's Insurance Card (including Insurance Card for Dependant).

新しく加入された「保険証のコピー」と

資生堂健康保険組合の「保険証（ご家族分も）の本証」

を必ず添付してください

Date of Enrollment for another Health Insurance: Reiwa [Year] [Month] [Date]

新しい保険証の資格取得日を記入

他保険に加入された日	令和	○ 年	○ 月	○ 日

○2. 死

[2. Due to the death of the Insured Person]

Please attach a copy of the death certificate and the Shiseido Health Insurance Society's Insurance Card (including Insurance Card for Dependant).

Please contact the Health Insurance Society as burial charges will be paid. (An application form will be sent to you.)

「死

資生

を必ず添付してください

Date of Death: Reiwa [Year] [Month] [Date]

で健保へご連絡ください（申請用紙を送付します）

死亡日	令和	年	月	日

Name of Applicant 申出者氏名	花椿　太郎	Relationship to the Insured Person 被保険者との続柄	本人
住　所 電話番号	〒 [Postal Code] [Address] [Phone Number]		

Note:
1. Insurance Premiums from the month of loss of entitlement onwards will be refunded.
However, if the date of loss and the month of acquisition of your insured status are in the same month, Insurance Premiums will not be refunded.
'The Refund Request Form(**還付請求書**)' will be sent to the relevant person separately after receipt of this application form.

【送付先】〒105-8310　東京都港区東新橋　1-6-2　資生堂健康保険組合　任意継続担当宛

Address and Phone Number for sending the application form

TEL　03-6218-5375

Internal