

Column to be filled out by the health insurance society	Standard monthly remuneration	,000 yen (in thousands of yen)						
	Applicable classification				Managing director	Clerical supervisor		Person in charge
	Issuance date:	(Y)	(M)	(D)				
	Effective date:	(Y)	(M)	(D)				

Request for Issue of Health Insurance Eligibility Certificate for Ceiling-Amount Application Form

*In order to pay the out-of-pocket limit at the counter, you need to apply to the health insurance society in advance and show your certificate before paying the medical expenses at the counter.

*The issuance date of the certificate is set as the first day of the month to which the application date (date of receipt by the Health Insurance Society) belongs. Please consult with the Health Insurance Society in urgent cases.

Current status of insured person	Insurance card code and number	Code 100	Emp. No. ○○○○○	Date of birth	(Y)	(M)	(D)	
		Number ○○○○○						
	Name of insured person	Furigana ケンポ タロウ Taro Kempo						
	Name of affiliated company	xxxxx Co., Ltd.						
	Name of affiliated department	XXXX Department XXXX Section			Telephone number:	03	(0000)	0000
	Address of the insured person	Postal code 151 - 0051	X-X-X Sendagaya, Shibuya-ku, Tokyo					
Current status of applicable person	Name of applicable person	Furigana ケンポ イチロウ Ichiro Kempo	Relationship with the insured person Eldest son	Date of birth	(Y)	(M)	(D)	
					2	0	0	
	Address of applicable person	Please write "same as above" if the address is the same as the insured person						
	Usage	<input checked="" type="checkbox"/> Hospitalization care costs			<input type="checkbox"/> Outpatient care costs (including the dispensing of prescriptions)			
Expected period of hospitalization or outpatient care	○○○○ (Y) ○ (M) ○ (D) to			○○○○ (Y) ○ (M) ○ (D)				
Desired destination for sending the ceiling-amount certificate	For urgent cases → Request receipt by around _____ (Y) (M) (D) *It may not be possible to meet your request depending on the transport conditions.							
	<input checked="" type="checkbox"/> Address of the insured person <input type="checkbox"/> Address of the eligible person <input type="checkbox"/> Other [Home / Hospital] *Please enter any necessary names (addressee/care of), room numbers, etc. Postal code _____ If you selected "Other," please write the desired address for sending.							

Please complete this section if the application is "to receive medical treatment for injury."	Was the injury caused by the actions of a third party (traffic accident, etc.)? ⇒ Yes / No
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Remarks	Individual number (not required when entering the code and number from the insured person's card)
	*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

A request is hereby made as detailed above for the issuance of an Eligibility Certificate for Ceiling-An
To the Executive Head of the Accenture Health Insurance Society

Date of submission:

Date request received (stamp)

Labor and social security attorney submitting the application on behalf of the insured	