

# Example of Completed Application

|   |                                  |                  |                  |
|---|----------------------------------|------------------|------------------|
|   | Managing director                | Office manager   | Person in charge |
| Health Insurance Application for Eligibility Certificate for Ceiling-Amount/Reduction of the Standard Amount of Patient Liability |                                  |                  |                  |
| Insurance card code and number  | Code                             | Number           | Emp. No.         |
|   | 100                              | 00000            | 00000            |
| Name of insured person  | Name                             |                  |                  |
|   | Date of birth                    |                  |                  |
| Taro Kempo<br>(Y) (M) (D)   |                                  |                  |                  |
| Office  | Office name                      |                  |                  |
|   | Address                          |                  |                  |
| xxxx Co., Ltd.  |                                  |                  |                  |
| Person applying for reduction   | Name                             |                  | Relationship     |
|   | Date of birth                    |                  | Gender           |
| Hanako Kempo  |                                  | Wife             | Male / Female    |
| May 2, 1975   |                                  | Male / Female    |                  |
| Address of insured person (person applying for reduction)   | Postal code                      | Telephone number |                  |
|   | X-X-X Kinshi, Sumida Ward, Tokyo |                  |                  |
| Long-term hospitalization   | Qualified / Not qualified        |                  |                  |

The following section can only be completed by applicants who are qualified as undergoing long-term hospitalization.

|     |   |  |                                       |
|-----|---|--|---------------------------------------|
|     |   | Total number of days hospitalized                                | (91 days)                             |
| (1) | Hospitalization period (number of days) during the 1 year prior to the application date | Date: From October 25, XXXX to December 14, XXXX                 | 51 days                               |
|     | Authorized insurance medical institution, etc., where hospitalized                      | Name of institution  | XXXX Association XXXX Hospital        |
|     |   | Address  | 1-1 XXXX-cho, Aoi Ward, Shizuoka City |
| (2) | Hospitalization period (number of days) during the 1 year prior to the application date | Date: From January 10, XXXX to February 18, XXXX                 | 40 days                               |
|     | Authorized insurance medical institution, etc., where hospitalized                      | Name of institution  | XXXX Association XXXX Hospital        |
|     |   | Address  | 1-1 XXXX-cho, Aoi Ward, Shizuoka City |
| (3) | Hospitalization period (number of days) during the 1 year prior to the application date | For the period from (Year) (Month) (Day) to (Year) (Month) (Day) | days                                  |
|     | Authorized insurance medical institution, etc., where hospitalized                      | Name of institution  |                                       |
|     |   | Address  |                                       |

|  |   |   |
|--|---|---|
| Desired destination for sending the Eligibility Certificate for Ceiling-Amount/Reduction of the Standard Amount of Patient Liability | <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. |   |

Section for listing individual number of insured person (not required when listing the code and number of the insured person's health insurance card)

I hereby attach the related documents and request the issuance of an "Eligibility Certificate for Ceiling-Amount/Reduction of the Standard Amount of Patient Liability" as stated above.

To the Executive Head of the Accenture Health Insurance Society

(\*) Section for certification by municipal head

This certifies that the insured person is not subject to the municipal tax in the \_\_\_\_ fiscal year.

Reiwa (Y) (M) (D)

(name of municipal head) (Seal)

Issuance date:

\*A tax exemption certificate for municipal tax can be attached instead of a certificate from the municipal head.

Please enter the name and date of birth for the person applying for reduction.

Please enter the relationship to the applicant as viewed from the insured person.

Please enter the address of the applicant.

Please circle one of the options regarding qualification for long-term hospitalization. A person is qualified for long-term hospitalization if the number of days hospitalized during the 12-month period prior to application (limited to the number of days hospitalized as an applicant for reduction) exceeds 90 days.

When qualifying as long-term hospitalization, please enter the hospitalization period.

Name and address of authorized insurance medical institution, etc., where hospitalized

Please use this section for listing proof from the municipal head in regards to taxation. It is not necessary to complete this section when attaching a tax exemption certificate.

## [Documents for Attachment]

- Persons who are exempt from municipal tax must attach a tax exemption certificate from the municipality. The attachment is not necessary if certification has been received in the certification section on the front of the application.
- For persons who are not required to be protected under the Public Assistance Act due to the reduction of the standard amount, please attach the "Notice of Rejection of Protection Application" that lists "Eligibility Certificate for Ceiling-Amount/Reduction of the Standard Amount of Patient Liability (C)," or the "Notice of Decision to Rescind Protection," or a copy of these documents with proof of the original from the employer, welfare officer, or welfare office manager.
- Persons who apply as qualifying for long-term hospitalization must attach a receipt for the standard amount. (If there is a period not associated with the standard amount during the hospitalization period, please attach documents certified by the authorized insurance medical institution, etc., for the hospitalization period).

## [Matters to Note]

- Please use this application form when the insured person is exempt from municipal tax for the fiscal year to which the month of medical treatment belongs.
- If you are injured or become ill during work or commuting, you cannot apply for a reduction certificate because you cannot use health insurance.
- Separate notification is required in the case of injury or illness caused by a third party such as a traffic accident. Please contact the health insurance society.