	Ciaiiii	ior Health II			neral Expense or Family Men	VVIII		sured person dies nily member applies	s)
Applicant information	Insurance card code and number	Code Num			Name of affiliated office/department		No need to fill		
	Name of applicant Ha		nnako Kempo		Applicant date of birth		••	(Y) •• (M) ••	(D)
	Address, telephone number, etc. of applicant (daytime phone number)	s, telephone tc. of applicant XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, To							
	Employee ID number	No	need to fil	Tin	E-mail address		XXXX@XXXX.ne.jp		
Application details	Date of death	Date of death $(Y) \bullet (M) \bullet ($			Cause of death Acute hea			Was it caused by the stions of a third party?	
	■ For application submitted upon the death of a family member  Name of family member  Please enter the applicant's information such as address, phone number, and email address.								
	<ul><li>(1) Died within 3 months after</li><li>(2) Died while continuing to r</li></ul>	nsurance society allowance after being d	health insurance code and number.  qualified from this health insurance ce to which he/she was previously  Name of insurer  Phone numb  Code and number			Phone number ( )	)		
Applica	■ For application submitted upon  Name of insured  person		he death of the insured person  Taro Kempo		Personal relation the insured p	erson and		Wife	
	Date of funeral				Buri	al		3	yen
	If you fall under one of the following categories, please enter name of the insurer and the code and number of the solin insurance in which the deceased had been enrolled after retirement.  Name of insurance in which is a spouse, child, or other person whose livelihood was disqualified (3) Died will supported by the insured person, there is no need to fill out the form.								)
	disqualified								
Column to be certified by the business owner	disqualified (3) Died w support	ease ask	your em not receive that de	ployer fove a cert		cate formate sales	or this	ocuments	
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Claim for Health Insurance Payment of Funeral Expenses (Costs) additional benefits
for Insured Person of Family Member

When a family member dies

	Insurance card	Code Number		Name of affiliated		XXXX Co., Ltd., XXXX Branch				
tion	code and number	••	• • XXXX		office/department		Telephone number (ext.) <b>03-1234-5678(999)</b>			
Applicant information	Name of applicant	Taro Kempo			App	plicant date of birth	(Y) ●● (M) ●● (D)			
Applican	Address, telephone number, etc. of applicant (daytime phone number)									
	Employee ID number	1234567			E-			XXXX	@XXXX.ne	.jp
S	Date of death	● (Y) ●	Cause of death Acute		heart failure		Was it caused by the actions of a third party?  Yes No			
	■ For application su	abmitted upon t	he death of a far	mily member (a	depe	ndent)				
	Name of family member	Hanako Kempo		Date of birth			● (Y) ● (M) ●		Relationship with the insured person	Wife
				-	e health	health insurance code and number.  Name of insurer  qualified from this health insurance				
etail		ceive the injury/illness a	allowance or maternity	allowance after being d					Phone number	( )
ion d	society to which he/she was previously enrolled (3) Died within 3 months after the end of receiving (2) after being disqualified from the health insurance enrolled									
Application details	For application su	ubmitted upon the	he death of the i	nsured person						
Appli	Name of insured					Personal relations	-			
	person  Date of					insured person Bur				
	funeral					exper				yen
	If you fall under one of the following categories, please enter name of the insurer and the code and number of the health insurance in which the deceased had been enrolled after retirement.  Name of									
	(1) Died within 3 months after being disqualified from this health insurance due to retirement, etc.  (2) Died while continuing to receive the injury/illness allowance or maternity allowance from this health insurance society after being									
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