常務理事	事務長	担当

☑ Report loss of "Certificate for limit Application"

□ Report loss of "Certificate of limit application / standard burden reduction"

□ Report loss of "Specific illness medical treatment certificate"

											he lost d		icate		
I have los												n /			
standard b			on and "	Specific 1	ılln	ess med	ical	treatr	ment ce	rtifi	cate″as				
described				1 1	т	• • • • • •	1.1		•1 • 1		. 1				
If I find												it of a	an		
accident i certificat		isurance b	enerits w	ith this r	iear	th insu	rance	e card	elderl	y ben	eliciary				
certificat	e.														
<u>Date</u>	Date							Name of insured person (applicant)							
	20	)21 / 1	/ 31				]	Kemp	o Taro						
	Code	1			Year Month Day Year Month D Date of							Day			
Insured card Coad / Number	lumbe	r 000	000	Date of birth		1980	1	0 0		ificat ion	2020	0 4	0 1		
Name of						Emp No. (涨)	0. 00000								
insured person		Kemp	o Taro				<b>〒</b> (postal code) <b>151-0051</b>								
N. 0						Address c	of								
Name of your office or					insured person	X - X - X		Sendagaya, Shibuya-ku, Tokyo							
department (※)						1	TEL	03	(XXXX)	XXXX					
Reason for sub	miss	ion 🔿													
(Please mar	k the		Loss												
applicable item circle)		tha 2.	Other (									)			
Applicable pers		Please mark	the applica	ble 🕦 Ins											
it	ems w	vith a circle	e)		urea	person	2. L	ependen	lls						
		Name				Re	lations	ationships	Date of	f	Year	Month	Day		
	(]	)							birth						
											Year	Month	Day		
Please fill in :			Name			Re			Date of	iear	Month	Day			
the person is a dependens	a 2	)							birth						
dependens											Year	Month	Day		
	0	Name	Name			Re	Relationships		Date of	f			1		
	3								birth						
	*	Please descr	ibe the cir	cumstances c	of th	e loss in	detai	11.							
Situation at the time of loss I accidentally discarded it at home.															
time of loss		accidenta	ily disca	arded 1t a	t h	ome.									
Status of polic	e Yes N		Notification					Notifi	cation		/	/			
notifications Comment field		162 . 110	police of	office		I		da	nte		/	/			
comment rielu								lth Insu			Date st	amp of	/		
								se fiel	u	1	accep	tance	ì		
						• Loss • Dependent (Transfer) • Update									
W Data of dolivory: ILi:/D-im- / /					•										
💥 Date of delivery: Heisei/Reiwa / /						· ·	Other	r							

(\*): If it was issued after you became Voluntary Continuation Health Insurance System, you do not need to fill in the form.