Claim for Health Insurance Payment of Funeral Expenses (Costs)additional benefits for Insured Person or Family Member

Applicant information

Insurance card code and number	Code	Number	Name of affiliated office/department	Phone number (Ext.)
Name of applicant			Applicant date of birth	(Y) (M) (D)
Address, telephone number, etc. of applicant (daytime phone number)	〒 Phone number (Ext.)			
Employee ID number			E-mail address	

Application details

Date of death	(Y) (M) (D)	Cause of death		Was it caused by the actions of a third party? Yes / No

■ For application submitted upon the death of a family member (a dependent)

Name of family member		Date of birth	(Y) (M) (D)	Relationship with the insured person	

If you fall under one of the following categories, please enter the name of his/her past insurer, and the health insurance code and number.

(1) Died within 3 months after being qualified as a dependent by this health insurance society

(2) Died while continuing to receive the injury/illness allowance or maternity allowance after being disqualified from this health insurance 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 to which he/she was previously enrolled

Name of insurer	Phone number ( )
Code and number	

■ For application submitted upon the death of the insured person

Name of insured person		Personal relationship between the insured person and applicant	
Date of funeral		Burial expenses	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.

(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 disqualified

(3) Died within 3 months after the end of receiving (2) after being disqualified

Name of insurer	Phone number ( )
Code and number	

Column to be certified by the business owner

Name ofthe deceased	Insured person or dependent	Date of death
	Insured person / Dependent	(Y) (M) (D)

I hereby certify that the above is true and correct. (Y) (M) (D)

Office address

Name of office

Name of employer Telephone number ( )

*If you wish to delegate receipt, please complete the authorization letter.

Authorization Letter

I hereby entrust the receipt of benefits based on this claim to the representative listed below. Date:

Insured person (applicant)	Name	
Representative (individual actually receiving benefits)	Name	

Information on transfer destination

Bank Number			Branch number	
Name of financial institution	Bank Shinkin bank (credit treasury)		Central branch branch	
Type of account	Savings account Other ( ) Checking account	Account number		Name of account holder (Katakana)

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

Section to be completed by the labor and social security attorney submitting the application on behalf of the insured

Date request received (stamp)

Accenture Health Insurance Society

(20220401)