Application for Health Insurance Eligibility Certificate

常務理事	事務長	担 当	係

◎Please check or fill in the reason (purpose) for application below.

☐ To enroll in National Health Insurance.
☐ To enroll as a dependent in the health insurance that family members are enrolled in.
☐ To use the system for direct payments to a medical care institution, etc., for a childbirth and childcare lump-sum grant, etc.
☐ Other (　　)

Information about Insured Person				
Symbol and Number of Insured person, etc.	Name			
*If unknown, enter the employee number.				
Business Entity Name	Birth Date			Gender
	Year	Month	Day	Male/Female

* For dependents, please fill in only for those who require certification.

	Name	Birth Date			Gender	Relationship
Dependents		Year	Month	Day	Male/Female	
		Year	Month	Day	Male/Female	
		Year	Month	Day	Male/Female	
		Year	Month	Day	Male/Female	
		Year	Month	Day	Male/Female	

Important Notes
・Only those who are (or were) members of our organization may apply.
・To issue a certificate of loss of eligibility, a notification of loss of eligibility (Notification of Health Insurance Dependent Change) must be submitted from the employer to our organization.
The certificate will be issued after the notification of loss of eligibility (Notification of Health Insurance Dependent Change) procedure with our organization is completed. Depending on the processing status, it may take some time for the certificate to be issued.
・For those who requested a certificate to be issued by your company at the time of resignation, please inquire with your company, as it will be issued by them.

Receipt Date Stamp

●I hereby apply for Health Insurance Eligibility Certification.

Applicant's Name	
Applicant's Address	〒 Phone Number or Mobile Phone Number (　　-　　-　　)

FR Health Insurance Organization