Example: If you have become eligible to receive a medical expense subsidy

提出日 2025 年 1 月 6 日
Submission date: (YYYY/MM/DD)

医療費助成制度該当届（新規・終了）
Notification of Eligibility for Medical Expense Subsidy System (New/Termination)

被保険者情報欄 Information about Insured Person

被保険者等の Insured Person's	記号Symbol: 1234 / 番号Number: 12345678 ※記号・番号が不明の場合は、番号欄に社員番号をご記入ください。 *If the Symbol/Number is unknown, please fill in your employee number in the number field.	氏名 Name	Mary Smith
住　所 Address	〒		
メールアドレス E-mail Address	※メールアドレスをご記入ください *Please fill in an e-mail address.		

We may contact you regarding the provided information. Please fill in an e-mail address.

助成対象者情報欄 Information about Eligible Person for Subsidy

フリガナ Furigana	Mary Smith	続柄 Relationship	MySelf	生年月日	Birth Date: 1977 年 YYYY / 10 月 MM / 1 日 DD
対象者氏名 Name of Eligible Person	Mary Smith FR健保の加入者であることをご確認下さい Please confirm the eligible person is a member of FR Health Insurance Organization				
受給制度 Benefit System （該当する項目に○印 Circle the applicable item(s)）	(1) ひとり親家庭等医療費助成 Medical care for single parent households expense subsidy 2. 心身障がい者医療費助成 Medical care for physically and mentally disabled persons expense subsidy 3. 妊産婦医療費助成 Medical care for expectant and nursing mothers expense subsidy 4. その他（　　） Other				
上記制度にいつから該当ですか When did you become eligible for the above system?	年 YYYY　月 MM　日 DD	※お手持ちの医療証の有効期限や交付日ではなく、上記制度に最初に該当となった日をご記入下さい *Please fill in the date you first became eligible for the above system, not the expiration date or issue date of your current medical care certificate.			
上記制度が終了した場合 If the above system has ended	2024 年 YYYY　12 月 MM　31 日 DD	※医療費助成制度が終了した場合その年月日をご記入下さい。 *If the medical expense subsidy system has ended, please fill in that date.			
この申請書を提出する理由 Reason for submitting this form	1. 医療費助成の該当となった（新規の認定 You have become eligible to receive a medica 2. 以前より医療費助成の該当であったが You were already eligible for a medical expens 3. FR健康保険組合に加入した You became a member of the FR Health Insurance Organization (4) 医療費助成が終了した A medical expense subsidy has ended				

If your medical expense subsidy has ended due to income restrictions or other reasons, please fill in that date.

● **市区町村等発行の「医療証（表・裏）」のコピーを必ず添付して下さい。**
Please be sure to attach a copy of your municipality-issued medical care certificate (front/back).

● 市区町村からの医療費助成と健保からの給付金が重複していたことが後日判明した場合、
給付金の返還請求が生じますので、届出もれの無いようご[illegible]ください。
If it is later discovered that municipal medical expense subsidy and benefits [illegible]lth Insurance Organization overlap, you may be required to return the benefits, so please be careful not to o[illegible]

A copy of your medical care certificate does not need to be attached when submitting “Notification of Eligibility for Medical Expense Subsidy System (Termination)”.

【注意事項】Important Notes

1. 本人が該当する場合も、「助成対象者情報欄」に記入して[illegible]
If the insured person is applicable, please fill in the “Information about Eligible Person for Subsidy Section”.
2. 所得制限等により、医療費助成制度に非該当となられた際は「医療費助成制度該当届（終了）」として提出して下さい。
If you become ineligible for the medical expense subsidy due to income restrictions or other reasons, please submit this as a “Notification of Eligibility for Medical Expense Subsidy System (Termination)”.
3. FR健康保険組合に加入されていない方については、お届け不要です。
Those who are not a member of the FR Health Insurance Organization do not need to submit this notification.
4. ご家族で医療費助成制度に該当の方が複数いらっしゃる場合は、お一人につき１枚該当届をご記入ください。（FR健康保険組合に加入されている方に限ります）
If multiple family members are eligible for the medical expense subsidy, please fill in one notification per person.
(Limited to those who are a member of the FR Health Insurance Organization)

送付先 Mailing Address
〒135-0063
東京都江東区有明１－６－７ 1-6-7 Ariake, Koto-ku, Tokyo
FR健康保険組合 宛 To: FR Health Insurance Organization

FR健康保険組合 〔R7.1〕
FR Health Insurance Organization (January, 2025)