1枚目 （被保険者記入用）
Page 1 (For Insured Persons to fill out)

◎この申請書は３枚一組です。This application form is a **set containing three pages.**

常務理事 ManagingDirector	事務長 OfficeManager	担当 PIC	係 Clerk

健康保険 Health insurance

傷病手当金請求書 ・ 同意書
Claim for Injury and Sickness Allowance

提出日　　年　　月　　日
Date of submission ___ / _ / _ (YYYY / MM / DD)

① 被保険者等 記号・番号 Symbol and Number of Insured person, etc.	記号 Symbol / 番号 Number ※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 enter your employee number in the number field.	② 被保険者 氏名 Name of Insured Person	
③ あなたの仕事内容（具体的に） Your Occupation (be specific)	※退職日以降の期間を請求する場合、退職前の業務内容をご記入ください。 * In the case of a claim for a period starting on or after the date when you left your employer, please enter the description of your work from before you left your employer.	④ 生年月日 Birth Date	年　月　日 ___ / _ / _ (YYYY / MM / DD)
⑤ 被保険者の（請求者）現住所 Address with Zip Code of Insured Person (Applicant)	（〒　　ー　　）		
⑥ メールアドレス Email Address	@		
⑦ 傷病名 Name of Illness or Injury		⑧ 発病または負傷の年月日 Date of Illness Onset or Injury	年　月　日 ___ / _ / _ (YYYY / MM / DD)
⑨ 傷病の原因について Cause of Illness or Injury	□不詳 Unknown　□交通事故 Traffic accident　□第三者行為によるもの An act by a third party　□その他（　） Other (　) ※仕事中、通勤途上、交通事故、加害者による負傷の場合は、必ず健康保険組合と勤務先にご連絡ください。 * In the case of an injury that occurs while you are at work, while you are commuting to work, or as the result of a traffic accident or act by a perpetrator, be sure to contact FR Health Insurance Organization and place of employment. ※仕事中や通勤途上の労災に該当する場合は請求できません。 * In the case of an injury due to an industrial accident that occurs while you are at work or while you are commuting to work, no claim can be made.		
⑩ 療養の為休んだ期間の傷病の状態を詳しく Details of Condition of Illness or Injury during Medical Care Leave	症状 Symptoms : 医師からの指示等 Instructions from a doctor, etc. :		
⑪ 療養のために休んだ期間（請求期間） Leave Period for Medical Care (claim period)	年　月　日 から From ___ / _ / _ (YYYY / MM / DD) to 年　月　日 まで……　日間 Days ___ / _ / _ (YYYY / MM / DD)	⑫ 労災保険からの休業給付補償の申請をしていますか Have you applied for leave benefit compensation from your Worker's Accident Compensation Insurance?	はい Yes ・ いいえ No
⑬ 「障害年金」または「障害手当金」を受給していますか Are you receiving a Disability Pension or Disability Allowance?	はい Yes ・ いいえ No ・ 請求中 Claim pending 受給しているものにチェック Tick all benefits you are receiving. □ 障害厚生年金 Disability Employees' Pension □ 障害基礎年金 Disability Basic Pension □ 障害手当金 Disability Allowance	※ 請求中の場合は誓約書が必要となります。 * If your claim is pending, you will need to submit an additional written pledge. ※ 年金額に変更が生じた際にはご連絡ください。 * If your pension amount changes, please contact us.	
⑬で「はい」もしくは「請求中」の場合 If you answered "Yes" or "Claim pending" in ⑬, please indicate the name of the illness or injury and pension amount.	傷病名 Name of the illness or injury 年金年額 Pension amount　　円 yen	基礎年金番号 Basic pension number 支給開始日 Payment start date	年　月　日 ___ / _ / _ (YYYY / MM / DD)
⑭ 《退職者の場合》老齢または退職による公的年金を受給していますか <For Retired Persons> Are you receiving public pension due to old age or retirement?	はい Yes ・ いいえ No ・ 請求中 Claim pending ⑭で「はい」もしくは「請求中」の場合 If you answered "Yes" or "Claim pending" in ⑭, please indicate the basic pension number and payment start date.	基礎年金番号 Basic pension number 支給開始日 Payment start date	年　月　日 ___ / _ / _ (YYYY / MM / DD)

２ページ目に続きます。
Continued on page 2.

受付日付印
Reception date stamp

2枚目 （被保険者記入用）
Page 2 （For Insured Persons to fill out）

◎この申請書は３枚一組です。This application form is a **set containing three pages**.

健康保険
Health insurance

傷病手当金請求書 ・ 同意書
Claim for Injury and Sickness Allowance

被保険者氏名 Name of Insured Person	

同 意 書 Letter of consent

FR健康保険組合 理事長殿 To the FR Health Insurance Organization Chairman of the Board:

健康保険法に基づく傷病手当金の支給決定を行うにあたり、FR健康保険組合が関係機関に対して、健康保険加入記録・保険給付記録・療養の給付記録・診療記録・年金等他の法令による保険給付受給に関する情報等の照会を行うこと、また、関係機関がFR健康保険組合の照会に対し回答をすること、及びFR健康保険組合がその回答を得ることに同意いたします。
In line with the decision to pay an Injury and Sickness Allowance based on the Health Insurance Act, I hereby agree to allow the FR Health Insurance Organization to inquire with related organizations regarding my health insurance enrollment record, insurance benefit record, medical care benefit record, medical treatment record, pension, and other information related to the receipt of insurance benefits in line with relevant laws and regulations, and I also agree to allow these related institutions to respond to inquiries from the FR Health Insurance Organization and to allow the FR Health Insurance Organization to obtain these responses.

※ 関係機関とは、前加入保険者、医療機関、年金事務所等を指します。
* Related institutions include past insurers, medical care institutions, pension offices, etc.

年 月 日
___ / _ / _ (YYYY / MM / DD)

被保険者氏名 Name of insured person ____________________

医師証明は３ページ目に続きます。
Continued with the doctor’s proof on page 3.

提出先 Submission recipient	※担当医師より、労務不能の意見の記入を受けた後、以下の宛先へご提出ください。 * After receiving your doctor’s opinion that you are unable to work, please submit the form to the appropriate recipient below.
在籍中の期間についての請求 Claims filed while enrolled	〒754-0894 山口県山口市佐山10717-1 （TEL：083-988-0306） 10717-1 Sayama, Yamaguchi, Yamaguchi Prefecture 754-0894 (Tel.: 083-988-0306) ㈱ファーストリテイリング 給与・社会保険チーム Payroll and Benefits Team, FAST RETAILING CO., LTD.
資格喪失後の期間についての請求 Claims filed after the loss of eligibility	〒135-0063 東京都江東区有明1-6-7 （TEL：03-6865-0005） 1-6-7 Ariake, Koto-ku, Tokyo 135-0063 (Tel.: 03-6865-0005) FR健康保険組合 給付担当 Person in charge of benefits, FR Health Insurance Organization

〔注意事項〕 Important Notes

1． 被保険者証の記号番号に代えてマイナンバーにより申請を希望する場合は健保組合までご相談ください。

If you wish to apply using your My Number instead of your insurance card symbol/number, please consult with the FR Health Insurance Organization.

2． 給付金支払先は、原則、給与振込口座となります。
給与口座以外への振込を希望される方は、金融機関名称、支店名、口座番号、口座名義の確認できるもののコピーを添付してください。
（振込は被保険者本人名義の口座に限ります。）

In general, benefits will be paid to the salary transfer account.
If you would like to transfer benefits to an account other than your salary account, please attach a copy of a document that can be used to confirm the financial institution name, branch name, account number, and account holder name. (Note that benefits can only be transferred to accounts in the name of the insured person.)

3枚目 （療養担当者記入用）
Page 3 (For the medical care provider to fill out)

傷病手当金請求書 Claim for Injury and Sickness Allowance

（3枚一組での申請になります）(Please submit all three pages as a set to apply.)

⑮ 患者氏名 Name of Patient		⑯ オンライン診療や患者の転居等により証明書原本のお渡しが困難で、PDFで交付した場合 In cases where it is difficult to hand over the original certificate due to the medical consultation being online or patient relocation, and it was issued as a PDF	□
⑰ 傷病名 Name of Illness or Injury	(1)	⑱ 療養の給付開始年月日（初診日） Medical Care Benefit Start Date (First Consultation Date)	(1) 年 月 日 __ / _ / _ (YYYY / MM / DD)
	(2)		(2) 年 月 日 __ / _ / _ (YYYY / MM / DD)
	(3)		(3) 年 月 日 __ / _ / _ (YYYY / MM / DD)
⑲ 発病または負傷の年月日 Date of Illness Onset or Injury	年 月 日 __ / _ / _ (YYYY / MM / DD)	⑳ 発病または負傷の原 Cause of Illness or Injury	

㉑ 労務不能と認めた期間 Recognized Period for Inability to Work	年 月 日 から From __ / _ / _ (YYYY / MM / DD) to 年 月 日 まで __ / _ / _ (YYYY / MM / DD) ………… 日間 Days
㉒ 診療実日数 Actual Number of Days of Medical Treatment	月 _ (MM) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 日間 days
診察日を〇で囲んでください Please circle the number of days of medical treatment.	月 _ (MM) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 日間 days
㉓ ㉑の期間中入院した場合にはその期間 Period of Hospitalization if Hospitalized During the Period in ㉑	年 月 日から From __ / _ / _ (YYYY / MM / DD) to 年 月 日まで __ / _ / _ (YYYY / MM / DD) ………… 日間 Days | 療養の別 Medical care type: 健保・自費・公費（ ）・その他 Health Insurance / Out of pocket / Public expenditure ( ) / Other | 転帰 Outcome: 治癒・継越・中止・転医 Recovered / Ongoing / Stopped / Doctor changed
㉔ ㉑の期間中における傷病の主状態及び経過の詳細について Main symptoms and progress details of Injury or Sickness During the Period in ㉑	
㉕ 通院指導について Regarding outpatient guidance	1. 入院中 2. ____日おきに通院 3. 週に____回通院 4. 月に____回通院 1. Hospitalized 2. Outpatient visit every ____ days 3. Outpatient visit ____ times a week 4. Outpatient visit ____ times a month 5. ____ヶ月に1回通院 6. 指示していない（指示をしていない理由を備考欄にご記入ください。） 5. Outpatient visit once every ____ months 6. Not instructed (Please state the reason for not giving instructions in the Remarks column.) 【備考】Remarks
㉖ ㉑の期間における治療内容、検査結果、療養指導等（詳しく） Treatment details, checkup results, and medical guidance during the period in ㉑	| ㉗ 投薬の有無 Medication | あり・なし Yes/No
㉘ 症状経過からみて従来の職種について労務不能と認められた医学的所見 Medical findings indicating inability to work in one's conventional occupation based on the progression of symptoms	

上記のとおり相違ありません。 I hereby certify that the above is correct 年 月 日 __ / _ / _ (YYYY / MM / DD)

医療機関所在地 Location of the medical care institution

医療機関名称 Name of the medical care institution

電話番号 Phone number （ ）

医師の氏名 Name of the doctor

※医療機関名等ゴム印を押印ください。
＊Please stamp the name of the medical care institution, etc.

【医師へのお願い】 [Requests for the doctor]

労務不能と認めた期間は、未来の証明はお受けできません。
Note that it is not possible to receive future proof of the Recognized Period for Inability to Work.
内容により、保険者より照会をさせていただくことがありますので予めご了承ください。
Please note that, depending on the details, the insurer might inquire with you.
訂正箇所は二重線で抹消後、正しい内容と証明者のサインをご記入ください。
To make a revision, please cross out the incorrect information with two lines, and then enter the correct details and provide a certifier signature.

To Those Who Request Injury and Sickness Allowance After Resignation
Continued Payments After Loss of Eligibility

Please submit the following documents when applying for Injury and Sickness Allowance after resignation.
1．「Daily Life and Medical Treatment Status Report」
2．Copy of the Benefit Period Extension Notice from your employment insurance
（You cannot make a claim if you are receiving unemployment benefits）
3．Copy of the Medical Treatment Statement issued by the medical institution
4．Copy of the Prescription Statement issued by the pharmacy

1. Benefits Available After Resignation

Even after resigning from your company and losing your eligibility as an insured person, you can continue to claim the Injury and Sickness Allowance as continued payments after loss of eligibility if you meet the payment requirements.
The payment period is no more than 1 year 6 months from the payment start date.
If you become able to work during this period, your right to receive benefits will cease at that point (you cannot receive benefits intermittently).

2. Payment Requirements (All of the following requirements must be met)

①	You must have been insured for 1 year or more
②	You must be receiving Injury and Sickness Allowance at the time of resignation (or be eligible to receive it)
③	You must continue to be unable to work after resignation (a doctor must certify that you are unable to work)

*If you report to work on your resignation date, you will not meet the eligibility requirements and will not receive Injury and Sickness Allowance after the resignation date.
*Determination of inability to work is based on the doctor's opinion and takes into consideration the nature of the work you performed while employed.

3．Payment Period

No more than 1 year 6 months from the payment start date (you cannot receive benefits intermittently after resignation)
If there is even a single day when you cannot receive benefits, the Injury and Sickness Allowance cannot be paid after that even if you become unable to work again due to the same illness.

4．Adjustment of Injury and Sickness Allowance Payments

If you are receiving Disability Employees' Pension, Disability Allowance, or Old-age Employees' Pension
If the amount of disability pension received for the same illness is less than the amount of the Injury and Sickness Allowance, the difference will be paid.
If the amount of Old-age Employees' Pension is less than the amount of the Injury and Sickness Allowance, the difference will be paid.
Please attach copies of the ●National Pension/Employees' Pension Insurance Certificate ● A recent pension transfer notice ● Disability certificate, etc.

*If the pension amount is revised while you are claiming Injury and Sickness Allowance, please notify the Health Insurance Organization promptly.

5．Review of Details

We may inquire with the insured person, doctor, or other party as necessary regarding the illness, injury, or other symptoms, visits to medical institutions (medication), past receipt of Injury and Sickness Allowance, and so on before making a decision regarding payment.
After a claim is filed, it may take time to reach a payment decision due to reviews based on the Health Insurance Act.
Please attach a copy of the Medical Treatment Statement and Prescription Statement issued by the medical institution (pharmacy) each time.

6．Notes on Filing Claims

・Since the Injury and Sickness Allowance is a benefit aimed at providing security for one’s livelihood, please try to claim it monthly.
・Please note that payment may be delayed if there are omissions or issues with the documents.

7．Claim Form Submission and Contact Information

For claims after resignation, please submit directly to the Health Insurance Organization.
Submission address: FR Health Insurance Organization 1-6-7 Ariake, Koto-ku, Tokyo 135-0063

（資格喪失者用） 傷病手当金 日常生活・療養状況報告書

For Those Who Have Lost Eligibility — Daily Life and Medical Treatment Status Report for Injury and Sickness Allowance

記入日 Date 年 月 日 (YYYY/MM/DD)

※任意継続被保険者の方も、在籍時の記号・番号をご記入ください。
*Voluntarily and Continuously Insured Persons should also fill in the symbol and number from when they were employed.

※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.

記号 Symbol	番号 Number	氏名 Name

◆請求期間と通院状況について◆
◆Claim Period and Outpatient Visits◆

請求期間 Claim Period	年 月 日(YYYY/MM/DD) ～ 年 月 日(YYYY/MM/DD)		
病院のかかり方について医師からどのような指示を受けていますか With regard to hospital visits, what instructions have you received from your doctor?	1. 入院中　2. ＿＿日おきに通院　3. 週に＿＿回通院　4. 月に＿＿回通院 1. Hospitalized　2. Outpatient visit every _____ days　3. Outpatient visit _____ times a week　4. Outpatient visit _____ times a month 5. ＿＿ケ月に＿＿回通院　6. 指示は受けていない（以下ア・イ・ウから選択してください） 5. Outpatient visit _____ times every _____ months　6. No instructions received (please select from a, b, or c below) ア. 自分の都合のよい日に行く　イ. 薬がなくなると行く a. Go on days convenient for me　b. Go when medication runs out ウ. その他（　　） c. Other (　)		
今回の請求期間中に、医師の診察を受けた日に○をつけてください Please circle the dates when you saw a doctor during this claim period.	月 month	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	受診日数 medical visit 日間 days
	月 month	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	日間 days
今回の請求期間中、医師の指示通りに受診ができなかった場合は、その理由をご記入ください If you were unable to visit the doctor as instructed during this claim period, please provide the reason.			

◆療養指示・療養状況について◆
◆Medical Treatment Instructions and Conditions◆

医師から療養についてどのような注意、指示を受けていますか What precautions or instructions have you received from your doctor regarding your treatment?	
お仕事に就くことができない状況をご記入ください（自覚症状など） Please describe the situation that is preventing you from working (subjective symptoms, etc.).	
請求期間中はどのような療養を行っていましたか。日常の過ごし方についてご記入ください What kind of medical treatment were you receiving during the claim period? Please describe your daily activities.	
いつ頃から仕事につくことができそうですか（アルバイトも含む） When do you think you will be able to work (including part-time work)?	1. ＿＿＿＿年＿＿月ごろ［＿＿月＿＿日より 就労 ・ 就労予定 ］ 2. 症状は軽快しているが、もうしばらく様子をみる 3. 継続して治療が必要で、就労は無理である 4. その他（　　） 1. Around [year] [month] [Started working/Plan to start working on [month] [day]] 2. Symptoms have improved, but need to monitor condition a while longer 3. Continued treatment is necessary, and working is not possible 4. Other (　　)

◆健康保険･雇用保険について◆

◆Health Insurance and Employment Insurance◆

現在加入している 健康保険について Current health insurance enrollment	記号･番号 （　　　　　　　　　） 保険組合名 （　　　　　　　　　） Symbol/Number (　　　　　) Name of Insurer (　　　　　) 1. 健康保険組合 （ 本人 ・ 家族 ） 2. 国民健康保険 3. 全国健康保険協会 （ 本人 ・ 家族 ） 4. その他 （　　　　　　　　） 1. Health Insurance Organization (Insured person ・ Dependent) 2. National Health Insurance 3. Japan Health Insurance Association (Insured person ・ Dependent) 4. Other (　　　　　)
ハローワークで 求職の申し込みを されていますか？ Have you applied as a job seeker at Hello Work?	1. 申し込みをしている 2. 給付の延長届を提出している 3. 申し込みをしていない（その理由 :　　　　　　　　） 1. I have applied 2. I have submitted an extension notice for benefits 3. I have not applied (Reason:　　　　　　　　)

◆添付書類について◆

◆Attached Documents◆

必要書類がもれなく添付 されているか提出前に ご確認ください（☑） Please check that all required documents are attached before submission. (☑)	☐ 診療明細書の写し Copy of Medical Treatment Statement ☐ 調剤明細書の写し Copy of Prescription Statement ☐ 受給資格者証の写し等 → ハローワークで求職の申込みをされている方は添付が必要です Copy of Qualification Certificate, etc. → Those who have registered as job seekers at Hello Work must attach documentation. ☐ 延長証明書の写し → ハローワークで給付の延長届を提出している方は添付が必要です Copy of Extension Certificate → Those who have submitted an extension notice for benefits at Hello Work must attach documentation.

●添付書類もれ、記入もれ、虚偽申告の場合、傷病手当金は支給できません。

● Injury and Sickness Allowance cannot be paid if documents are missing, information is incomplete, or false declarations are made.

●報告書の記入内容について、担当医師に確認をさせていただく場合もあります。

● We may verify the contents of this report with your doctor.