Confirmation	
☐	❶ As for this notification, it meets the requirements of 1. or 2. 1. It is prepared by the applicant (insured) or the applicant's representative. 2. The applicant or the applicant's representative confirms that there are no errors in the contents.

Request for Eligibility Certificate for Ceiling-Amount Application

❷

【Note】If you need to correct the contents that you have filled out, erase the areas that have been corrected with a double line and fill in the correct contents.
A full name signed is required near the duplex.

❸ Insured person									
	Insurance card ❹	Code		Number					
	Insured person	Name							
		Date of birth		D		M		Y	
	Address/Phone	〒 —							
		— —							

Applicable person																
	❺ Applicable peson	Name												Relationship with the Insured		
		Date of birth		D		M		Y								
	❻ Planned duration of hospitalization or outpatient treatment	from		D		M		Y	to		D		M		Y	
		※ The effective date is the first day of the month in which this application arrived at Health Insurance Society. The certificate for the month before the application arrives cannot be issued.														

Destination		
	❼ Send to	☐ Workplace ☐ Insured person's address ☐ Elsewhere
	If you want to send it to an address different from the insured person's, fill it in.	
	Address/Phone	〒 — — —
	Addressee	

Proxy application			
	❽ Fill in this column when this application is made by other than the insured person.		
	Name		Relationship with the Insured
	Phone	— —	
	Reason for substitute for application	☐ The insured person has been hospitalized. ☐ Other ( )	

※ The expiration date is the end of August every year, regardless of the month of application. If you need a certificate from August to September, submit two application forms.

e.g. When the planned period of treatment is "August 25-September 15"

- 1st sheet from 25/8 to 31/8
- 2nd sheet from 1/9 to 15/9

❶ Confirmation
Ensure that there are no errors in the entries, and submit it by making a ✓.

❷ Note
If you need to correct the contents that you have filled out, erase the areas that have been corrected with a double line and fill in the correct contents.
A full name signed is required near the duplex.

❸ Insured person
Even if the family(dependent) needs a certification, fill in the information of the insured(employee).

❹ Code,Number
Enter the code（記号） and number（番号） of the insurance card accurately.

❺ Applicable person
If a family member(dependent) is eligible, fill in the information of the dependent.

❻ Planned duration of hospitalization or outpatient treatment
If the period of time is undetermined, fill in the scheduled term.
※ The effective date is the first day of the month in which this application arrived at Health Insurance Society.
The certificate for the month before the application arrives cannot be issued.

❼ Destination
Select the desired destination.
As a general rule, it is sent to employees by the Human Resources Department.

❽ Proxy application
If the application is made on beharf of a person(dependent or non-dependent) otner than the insured, enter the information.