Column to be filled out by the health insurance association											
	Standard monthly remuneration					,000 yen (in thousands of yen)					
	Applicable classification						Managing director	Clerical supervisor		Person in charge	
	Issuance date:	Reiwa	(Y)	(M)	(D)						
	Effective date:	Reiwa	(Y)	(M)	(D)						

Request for Issue of Health Insurance Eligibility Certificate for Ceiling-Amount Application Form

***In order to pay the out-of-pocket limit at the counter, you need to apply to the health insurance association in advance and show your certificate before paying the medical expenses at the counter.**

***The issuance date of the certificate is set as the first day of the month to which the application date (date of receipt by the Health Insurance Association) belongs. Please consult with**

Current status of insured person	Insured person code and number	Code		Number		Date of birth	Showa Heisei	(Y)	(M)	(D)		
	Name of insured person	Furigana										
	Name of affiliated company											
	Name of affiliated department				Telephone number: ( )							
	Address of the insured person	Postal code –			Telephone number: ( )							
Current status of applicable person	Name of applicable person	Furigana		Relationship with the insured person		Date of birth	Showa Heisei Reiwa	(Y)	(M)	(D)		
	Address of applicable person	Postal code – (*Write "same as above" if the address is the same as the insured person)			Telephone number: ( )							
	Usage	☐ Hospitalization care costs		☐ Outpatient care costs (including the dispensing of prescriptions)								
	Expected period of hospitalization or outpatient care	Reiwa (Y) (M) (D) to Reiwa (Y) (M) (D)										
Desired destination for sending the ceiling-amount certificate	Reiwa (Y) (M) (D) *It may not be possible to meet your request depending on the transport conditions.											
	☐ Address of the insured person ☐ Address of the eligible person											
	☐ Other [Home / Hospital] *Please enter any necessary names (addressee/care of), room numbers, etc.											
	Postal code –											

Please complete this section if the application is "to receive medical treatment for injury."	Was the injury caused by the actions of a third party (traffic accident, etc.)? ⇒ Yes / No	

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

A request is hereby made as detailed above for the issuance of an Eligibility Certificate for Ceiling-Amount. Date of submission:

To the Executive Head of the Western Digital Technologies Health Insurance Association Date request received (stamp)

Labor and social security attorney submitting the application on behalf of the insured	