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**

Current status of insured person

Insured person code and number	Code	100	Number	○○○○○	Date of birth	Showa / Heisei	(Y) 5	3	(M) 0	6	(D) 0	7
Name of insured person	Furigana	ケンポ　タロウ										
	Taro Kempo											
Name of affiliated company	xxxxx Co., Ltd.											
Name of affiliated department	XXXX Department　XXXX Section				Telephone number:	03 (○○○○) ○○○○						
Address of the insured person	Postal code 151 – 0051											
	X-X-X Sendagaya, Shibuya-ku, Tokyo											
					Telephone number:	03 (○○○○) ○○○○						

Current status of applicable person

Name of applicable person	Furigana	ケンポ　イチロウ		Relationship with the insured person	Eldest son	Date of birth	Showa / Heisei / Reiwa	(Y) 1	0	(M) 0	1	(D) 0	1
	Ichiro Kempo												
Address of applicable person	Postal code –												
	Please 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

For urgent cases → Request receipt by around _____(date) *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 –

If you selected “Other,” please write the desired address for sending.

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-A

Date of submission:

To the Executive Head of the Western Digital Technologies Health Insurance Assc

Date request received (stamp)

abor and social security attorney submitting the application on behalf of the insure	