

Notification of Change of Covered Dependents (Addition)

常務理事	事務長		担当

Insurance card code and number	Name of the insured person	Furigana			Date of birth			Gender	Date of acquisition of eligibility		
		(Y)	(M)	(D)	Male	(Y)	(M)	(D)			
Address of the insured person		Telephone			Standard monthly remuneration			,000 yen (in thousands of yen)			

Type of change	Name of dependent		Date of birth			Gender	Relationship	Occupation or year in school	Annual expected income (including tax)	Household	Day on which support began			Individual Number	
	(Last name)	(First name)	(Y)	(M)	(D)						(Y)	(M)	(D)	Reason/Remarks	
Addition	Furigana		(Y)	(M)	(D)	M		yen	Living together	(Y)	(M)	(D)			
	(Last name)	(First name)				F				Living separately					
Addition	Furigana		(Y)	(M)	(D)	M		yen	Living together	(Y)	(M)	(D)			
	(Last name)	(First name)				F				Living separately					
Addition	Furigana		(Y)	(M)	(D)	M		yen	Living together	(Y)	(M)	(D)			
	(Last name)	(First name)				F				Living separately					
Addition	Furigana		(Y)	(M)	(D)	M		yen	Living together	(Y)	(M)	(D)			
	(Last name)	(First name)				F				Living separately					
Addition	Furigana		(Y)	(M)	(D)	M		yen	Living together	(Y)	(M)	(D)			
	(Last name)	(First name)				F				Living separately					

事業主の 確認 電	事業所所在地
	事業所名称
	事業主氏名
	電話

Date of submission (Y) (M) (D)

受付日付印

社会保険労務士の提出代行記載欄

To the Western Digital Technologies Health Insurance Association