Written Notice for Acquisition of Qualification as a Voluntarily and Continuously Insured Person

Managing director	Clerical supervisor		Person in charge

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

Reiwa (Y) (M) (D)

Code and number at time of loss of qualification	Code		Number	
Name	Furigana			
Applicant's address	Postal code Home telephone ( )		Mobile ( )	
Date of birth	Showa / Heisei (Y) (M) (D) Age:		Gender	Male / Female
E-mail address (address where contact is possible after retirement)				
Date of loss of qualification (day following retirement)	Date:			
Name of affiliated company at time of losing qualification				
Name of affiliated department at time of losing qualification				
Designated destination for remittance of benefits, etc.	Bank: Shinkin bank		Central branch	
	Savings account	Account number	Name of account holde	
Payment method for insurance premiums	1. Monthly	2. Advance payment of 1 year's worth of premiums	3. Advance payment of 6 month's worth of premiums	
Insured person consent section	I consent to procedures for loss of qualification being taken if confirmation cannot be made of premium remittance by the premium payment deadline date. Name of insured person			

Status of dependent

Name	Date of birth	Gender	Relationship	Address
	S / H / R (Y) (M) (D)			
	S / H / R (Y) (M) (D)			
	S / H / R (Y) (M) (D)			
	S / H / R (Y) (M) (D)			

(Note) Please note that this application will not be accepted if it is not delivered to the health insurance association within 20 days from the date on which qualification was lost.

Remarks	
	Individual number (not required when entering the symbol 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

Date request received (stamp)

*Column to be filled out by the health insurance association

Voluntarily and continuously insured person insurance code and number		
Scheduled date of loss of qualification	Date:	
Standard monthly remuneration at time of loss of qualification		,000 yen (in thousands of yen)
Set monthly amount		,000 yen (in thousands of yen)
Date of first premium payment		