Letter of Consent

To the Western Digital Technologies Health Insurance Association

I agree to provide payment and treatment records as well as any other documents to relevant agencies (*1) of the Western Digital Technologies Health Insurance Association and to answer any questions pertaining to this Application for Injury and Illness Allowance.

I also understand copies of this application shall be treated the same as the original application.

(*1) Relevant agencies refers to health insurance societies providing coverage to the individual and medical institutes and other providers rendering medical services.

(Y) (M) (D)

Address

Name

1. Please fill in information about your health insurance before joining the Western Digital Technologies Health Insurance Association.
(This information is not required if you were previously a member of the Hitachi Health Insurance Association.)

Name of the insurer (*2)	
Code－Number	－
Period insured	(Y) (M) to (Y) (M)
Eligibility	□ Insured Person □ Dependent (The information below is not required for dependents.)
Employer	
Address	
Telephone number	

(*2) Example: XX Health Insurance Society or XX Mutual Benefit Association
Please provide the name of the municipality if you were locally enrolled in National Health Insurance.

2. Please provide your basic pension number.

Basic pension number	―

[Name of applicant] _____
[Telephone number] _____

*The HGST Health Insurance Association will proceed with its decision on payment of the injury and illness allowance according to the information that you have provided.
Please provide a telephone number where you can be reached with any questions which may arise regarding your application.