

Email submissions not accepted.

Example of entry

Health Insurance

Insured person

Dependents

Claim for Medical Expenses (Advance Payment, etc.)

Column to be filled out by the insured person (employee)	Insurance Code - Number	99-99999		Name of insured person	健保 太郎		
	Global ID	1234567					
	Company	○△◇ 株式会社		Date of birth	〇〇年(Y) 〇〇月(M) 〇〇日(D)		
	Name of injury or illness	インフルエンザ		Date injury or illness first occurred	〇〇年(Y) 〇〇月(M) 〇〇日(D)		
	Cause of illness or injury	帰省中に高熱が出た。		Was it caused by the actions of a third party?	Yes <input type="radio"/> No <input checked="" type="radio"/> ※If yes, please contact AIG Health Insurance Association in advance.		
	Treatment period	From 〇〇年(Y) 〇〇月(M) 〇〇日(D) To 〇〇年(Y) 〇〇月(M) 〇〇日(D)	Days	1 日(D)	Inpatient or Outpatient	Inpatient <input type="radio"/> Outpatient <input checked="" type="radio"/>	
	Content of treatment	診察及び投薬を受けた。		Cost of medical care	5,000 円(yen)		
	Reason for claim for payment of medical expenses	保険証を持っていなかった為					
	Medical institution	Name and Doctor's name	〇〇医院 〇〇 一彦				
		Address and Telephone number	〒999-0000 TEL 03-9999-9999 東京都〇〇区〇〇〇町2-2-2				
Name(when the target person is a dependent.)	健保 花子 Relationship with the insured (妻)		Date of birth(when the target person is a dependent.)	〇〇年(Y) 〇〇月(M) 〇〇日(D)			
I claim the benefits in this case as described above. Date 〇〇年(Y) 〇〇月(M) 〇〇日(D)							
In the case of an insured person in employment, the recipient of the Benefit shall be entrusted to the employer. (※) 〒999-0000 東京都〇〇区〇〇〇町2-2-2 Full name of the insured 健保 太郎 To the Chairman of the AIG Health Insurance Association (*)The deadline for this application is the 15th of every month. It will be paid together with the next month's salary. (In the case of voluntary and continuously insured persons, transfer to the registered account on the 20th of the following month)							

*Please fill out this claim form and submit it with the following documents.

Acceptance stamp

Attached documents

[If you receive medical treatment at your own expense.]

- ① Medical cost and treatment details(診療報酬明細書) issued by medical institutions, etc. (original)
In the case of a pharmacy, the dispensing cost and prescription details(調剤報酬明細書).
- ② Receipts (original)

[If you have received a medical treatment with National Health Insurance or your previous health insurance.]

- ① Medical cost and treatment details(診療報酬明細書) issued by National Health Insurance or your previous health insurance. (original)
- ② Receipts issued by National Health Insurance or your previous health insurance. (original)

※Medical cost and treatment details(診療報酬明細書)/Dispensing cost and prescription details(調剤報酬明細書) must be submitted unopened.

Notice

Please prepare one copy for each patient by month of medical examination, by outpatient and inpatient, and by medical institution and pharmacy.

Submission destination

Please submit to the Human Resource Partners (Labor & Social Security Attorneys Office)

Address: 19th floor, IMP Building, 1-3-7 Shiromi, Chuo-ku, Osaka-shi, 540-6319 Japan

Team for AIG , Human Resource Partners (Labor & Social Security Attorneys Office)

*If you are a voluntary and continuously insured persons, please send the claim form directly to AIG Health Insurance Association.

2025/4