Email submissions not accepted.

Example of entry

Health Insurance　Insured person (Dependents)

Claim for Medical Expenses (For therapeutic devices)

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	〇△◇　株式会社		Date of birth	〇〇年(Y)　〇〇月(M)　〇〇日(D)
Name of injury or illness	リンパ浮腫		Date injury or illness first occurred	〇〇年(Y)　〇〇月(M)　〇〇日(D)
Cause of illness or injury	乳がんの術後		Was it caused by the actions of a third party?	Yes ・ No ※If yes, please contact AIG Health Insurance Association in advance.
Name of therapeutic devices, etc	弾性スリーブ		Cost of therapeutic devices, etc	15,000 円(yen)
Medical institution	Name of medical institution and doctor	〇〇病院　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

Address of the insured　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.**

Attached documents

【For therapeutic devices】

① Physician's certificate, instructions

② Receipt(original)

※If the breakdown and details are not stated in the receipts, please attach the statement (breakdown).

③ For shoe-type therapeutic devices, please attach a photograph.

※The following four shots must be taken

Front, back (opposite side of front), side (right or left), and logo, size, part number(if any), etc.

【For therapeutic eye glasses】

① Copy of written instructions, issued by an insurance physician

② Patient's test result

③ Receipt(original)

※If ① contains test results, ② does not need to be submitted.

Notice

Cash register receipts will not be accepted.

Acceptance stamp

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.

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