Health Insurance Insured person

Dependent

Claim for Childbirth and Childcare Lump-sum /Additional Sum

Column to be filled out by the insured person (employee)	Insurance Code - Number			-			Name of insured person						
	Global ID						·						
	Company						Date of birth		年(Y)	月 (M)	日	(D)	
	Medical	Name											
	Medical institution	Address	₹										
	Delivery date			年 (Y)	月 (M)	日(D)	Live birth or Stillbirth	Live birt	h · Stillbirth · Mix	xture of live birth	n and stillb	oirth	
filled	Number of babies born		Live birth	n() ·	Stillbirth ()	In the case of stillbirth				Month		
out b						,	Weeks of pregnancy				Week		
y the in	Name of the family member who gave birth		Relation	nship with the	insured ()	Date of birth of the family member who gave birth		年(Y)	月 (M)	日	(D)	
sured	I claim the benefits in this case as described above.							Date	年 (Y)	月 (M)	В	(D)	
perso	In the	In the case of an insured person in employment, the recipient of the Benefit shall be entrusted to the employer. (※)											
on (er	₹												
nploy	Address of the insured												
ee)													
	Full name of the												
		insured											
	Daytime contact ()												
	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	e deadline for this			every mo	nth. It will b	e paid together with the	next mo	onth's salary.				
Med			s application is	the 15th of	-		e paid together with the		20th of the follow				
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edical do		e case of volunta	s application is	the 15th of ously insur	ed person	s, transfer to	the registered accoun	t on the	20th of the follow 生産		週)		
edical doctor/n	ŀ	e case of volunta 出産年月日 出生児の数	s application is	the 15th of ously insur 年	ed person	s, transfer to 日	o the registered accoun 生産・死産の別	t on the 2	20th of the follow 生産 妊娠第 月	· 死 産	週)		
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edical doctor/midwife or municipal n	ŀ	e case of volunta 出産年月日 出生児の数)とおり相違ないる 年 医療機関等の名 所在地 医師・助産師名	s application is iry and continue ことを証明する。 月	the 15th of ously insure 年	ed person	s, transfer to 日	o the registered accoun 生産・死産の別	t on the 2	20th of the follon 生產 妊娠第 月	· 死 産	週)		
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edical doctor/midwife or municipal mayor's certificat	上記の出	e case of volunta 出産年月日 出生児の数 ひとおり相違ないこ 年 医療機関等の名 所在地 医師・助産師名 本 籍 は生届年月日	s application is rry and continue ことを証明する。 月 「称・ 〒 年	年 日 日	ed person 月 単 服	s, transfer to	o the registered accoun 生産・死産の別	t on the 2	20th of the follow 生産 妊娠第 月 児)	・死産		日	
Medical doctor/midwife or municipal mayor's certificate column	上記の出	e case of volunta 出産年月日 出生児の数)とおり相違ないる 年 医療機関等の名 所在地 医師・助産師名 本 籍 出生届年月日	s application is ry and continue ことを証明する。 月 ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・	年 日 日 日	ed person 月 単 服	s, transfer to	o the registered accoun 生産・死産の別	t on the 2	20th of the follow 生産 妊娠第 月 児)	・死産		日	

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

All three are issued by the medical institution.

(1)Copy of agreement document with the medical institution.

 $@ AIG \ health \ insurance \ association \ name \ @ \ Indication \ of "I \ don't \ agree \ with \ the \ direct \ payment \ system" \ @ Name \ of \ insured \ person \ agree \ with \ the \ direct \ payment \ system" \ @ Name \ of \ insured \ person \ agree \ with \ the \ direct \ payment \ system" \ @ Name \ of \ insured \ person \ agree \ with \ the \ direct \ payment \ system" \ @ Name \ of \ insured \ person \ agree \ with \ the \ direct \ payment \ system" \ @ Name \ of \ insured \ person \ agree \ with \ the \ direct \ payment \ system" \ @ Name \ of \ insured \ person \ agree \ with \ the \ direct \ payment \ system" \ @ Name \ of \ insured \ person \ agree \ person \ agree \ person \ agree \ payment \ payment$

Name of medical institution and representative

(2)Copy of delivery expense itemized statement

ODelivery date O Number of babies born O Indication of "Not using the direct payment system" ODelivery expense

(3)A copy of the receipt (stamped by an institution affiliated with the Obstetric Care and Compensation System

or "the delivery is covered by the Obstetric Care Compensation Program." is clearly stated.)

% If (2) has a stamp or text, then (3) is not required to be submitted.

XIf the birth is not covered by the obstetric care compensation system, there is no stamp or text.

Notice

Attached documents

* If you paid the full amount of delivery expense without using the direct payment system, please fill out the [Medical doctor/midwife or municipal mayor's certificate column]

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.