Email submissions not accepted.

Example of entry

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		99 ー 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)
Medical institution	Name	〇〇〇産婦人科医院		
	Address	〒999-0000 東京都〇〇区〇〇〇町１ー１ー１		
Delivery date		〇〇 年(Y)　〇〇 月(M)　〇〇 日(D)	Live birth or Stillbirth	Live birth ・ Stillbirth ・ Mixture of live birth and stillbirth
Number of babies born		Live birth (1) ・ Stillbirth ( )	In the case of stillbirth Weeks of pregnancy	Month Week
Name of the family member who gave birth		健保　花子 Relationship with the insured (妻)	Date of birth of the family member who gave birth	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. (※)

Address of the insured　〒999-0000 東京都〇〇区〇〇〇町2ー2ー2

Full name of the insured　健保　太郎

Daytime contact　03（〇〇〇〇）××××

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)

Medical doctor/midwife or municipal mayor's certificate column

出産年月日	年　月　日	生産・死産の別	生　産　・　死　産 （妊娠第　月又は第　週）
出生児の数	単　胎　・　多　胎　（　児）		

上記のとおり相違ないことを証明する。
年　月　日
医療機関等の名称・所在地　〒
医師・助産師名

Column to be filled out by the medical doctor/midwife

本　籍		筆頭者氏名	
出生届年月日	年　月　日	出生年月日	年　月　日

上記のとおり相違ないことを証明する。
年　月　日
市 区 町 村 長 名　㊞

Column to be filled out by the municipality

Seal stamping cannot be omitted. (Not required if certified by the hospital)

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

Attached documents

All three are issued by the medical institution.

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

①AIG health insurance association name ② Indication of "I don't agree with the direct payment system" ③Name of insured person ④Name of medical institution and representative

(2)Copy of delivery expense itemized statement

①Delivery date ② Number of babies born ③ Indication of "Not using the direct payment system" ④Delivery 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.

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

Notice

*** 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.

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