

- ① Date of Illness or Injury
- ② Name of Illness or Injury / Cause of Illness or Injury (where, how)
- ③ The name of the person who received medical treatment
- ④ Circle a response to indicate whether the issue is job-related or related to a third-party act.
1. Job-related 2. Third-party act 3. Other
- ⑤ Place of treatment (Enter in the case where the address is different from the address of the insurance card, such as the facility to live in or the exception of address.)
- ⑥ Name of Insured Person
 - * Please read the information and then sign.
- ⑦
 - Ask the medical treatment manager to fill out the medical treatment detail field and medical treatment certification field.
 - For the payment organization field, enter the account under the name of the insured person.
 - If attaching the original consent form, it is not necessary to fill out the consent record. However, if you are attaching the original consent form for an application covering the previous month or earlier and the period during which payment is possible based on this consent form is still ongoing, please fill out the consent form details on the consent record.
 - When submitting the application, be sure to attach the receipt (original) indicating the costs necessary for the medical treatment.