_____ Insurance Company, **_____ Society-Managed Health Insurance, Employer**

Overseas Travel Insurance Claim Form / Overseas Medical Expenses Application Form

[1] I hereby make a claim for insurance benefits, by confirming the accuracy of the contents hereof and also by agreeing to the matters mentioned below

Authorization for my personal information

I agree that you and your entrusted company acquire all my medical information with respect to any my consultation and treatment directly from the hospital and use it, and, acquire, use, provide or register my privacy information regarding this consultation and treatment to the extent necessary to achieve the use purposes following:

①that you may provide the information with entrusted company(including insurance agency), medical institution, parties related to claim or payment of insurance money, parties related accident or others, or to be provided the information by these persons,

②that in case of concurrent contracts (meaning insurance contracts, mutual aid contracts, etc., irrespective of their names. Hereinafter 'Other insurance contracts') which pays for the same damages or expenses of this insurance claims, for the purpose of compensation claim for the amount in excess of your liability to the insurance companies, mutual aid associations, etc. which is responsible for the other insurance contracts, you may provide the information to the insurance companies, mutual aid associations, etc., or receive such information from those companies and make use of it, and vice versa.,

③that you may provide the information with the Non-life Insurance Association of Japan or other non-life insurance company or others or register it for the purpose of sound management of insurance system ,or to be provided the information by these persons,

④that you may provide the information with reinsurance company, etc.(including the case where the reinsurance company, etc. provides the information to other reinsurance company, etc.) in order to enter into a reinsurance contract or receive reinsurance claim ,etc.,

⑤that my employer, the entrusted company, Labor and Social Security Attorney, and Society-Managed Health Insurance may acquire and use the information for allowance of overseas medical expenses by the Society-Managed Health Insurance,

⑥that my employer and the entrusted company may acquire and use the information for allowance of company benefits.

＜To: Society-Managed Health Insurance ＞

I hereby claim medical expense(s) which will be paid by Society-Managed Health Insurance. I authorize a Labor and Social Security Attorney who has signed a separate agreement regarding having the authority of acting on behalf of the employer to handle my medical expense(s) claim and receipt.

Authorization for cashless medical service

I authorized WellBe International Loss Adjusters Limited to claim and receive insurance money and benefit (for the medical expenses and other expenses related to my treatment, such as transportation fee and medical interpreter's fee) if I have used cashless medical service. In case it is turn out that I do not have any rights to claim the medical expenses, I pledge myself to pay such medical expenses to the hospital, WellBe International Loss Adjusters Limited or the above insurance company without delay.

Date _____ **(dd/mm/yyyy)** **Signature**_____

※Please sign by yourself, or If the insured is child, parent's signature is also authorized.

Please sign here if the patient is not an employee. This is to claim to Society-Managed Health Insurance. ⇒ ⇒ ⇒

EMPLOYEE SIGNATURE：

[2] Society-Managed Health Insurance ID：

Policy No.：		Policy Period：From To
Name：		**English Name：**
Sex： M / F	**Age： Date of birth：**	**Company Name：**
Address：		**Address in Japan：**
E-mail:		
Tel ：（ ）		**Tel ：（ ）**

Do you have any concurrent insurance policies covering the same risk ? No / Yes [ ]

[3] Details of accident or sickness

Accident ：Date of occurred	**Place：**
Sickness：Date of first symptom	**Hospital / Clinic:**
Details： Please describe the accident, injury or sickness in detail.	
Reason of unable to receive medical benefits ： *be assigned abroad,*	
Any treatment before on same symptom? （Yes / No ） **If Yes, When ：** _____ **Diagnosis ：** _____ **Hospital ：** _____ **Completely cured? （ YES →【 When: 】 / NO ）** **Need an interpreter? (YES 【Signature: 】 / NO)**	