

Example

K-031 P ( )

日立健康保険組合 御中

健康保険 傷病手当金請求書 Health Insurance Claim for Injury and Sickness Allowance

\*太枠線内を記入してください(記入要領等は、別紙「記入例」をご参照ください)

1	提出日 Submission date	令和〇〇年4月25日	備考	
	被保険者証 記号・番号 Health insurance card code and number	記号 番号 1 0 0 0 1 0 0 0 0 0 0	被保険者名 Name of insured person	(7桁) ケンゾ マサミ 健保 正美
	事業所 (会社)名称 Office (company) name	株式会社〇〇〇〇〇	従業員番号 Employee no.	〇〇票
	連絡先住所 Contact Address	〒000-0000 〇〇県〇〇市〇〇町1-1-1	所属・電話 Affiliation and telephone number	(直: 000-000-0000)
2	傷病名 Name of injury/illness	胃潰瘍	発病又は 負傷の年月日 Date of onset of injury/illness	平成〇〇年3月1日(頃)
	傷病又は負傷 の原因 Cause of injury/illness	不明	傷病又は負傷 の休んだ期間 Period off from work due to injury/illness	平成〇〇年3月11日から 令和〇〇年3月31日まで
3	4	5	6	7
4	Did you receive any remuneration for the period off from work for treatment?	Received	Received	Didn't receive
5	If you were paid remuneration, the amount thereof and period on which the remuneration was based	令和〇〇年〇月〇日 から 令和〇〇年〇月〇日 まで	円	
6	If you were paid remuneration, the amount thereof and period on which the remuneration was based	有・無・請求中 ( 年 月 から受給)	年金証書の 基礎番号 Pension certificate basic no.	
7	受給病名 Illness for which allowance was received		障害・厚生年金 手当金の年額 Annual amount of disability/employees' pension allowance	円
8	第三者の行為によって負傷したものであるか、ないかの別 Was it due to the actions of a third party (e.g. traffic accident, act of violence)?	有 Yes	無 No	
9	Does this application concern a period for which compensation benefits for absence from work are received under Worker's Accident Compensation Insurance?	はい Yes	労働請求中 Workers' Accident Compensation Insurance claim in process	いいえ No
10	(Optional) 医師に照会が必要 な場合の事前同意 Prior consent if referral to a doctor is required	I consent to the Hitachi Health Insurance Society confirming and investigating the details with doctors and business owners, etc., when claiming the injury and sickness allowance. 被保険者氏名 Name of insured person 健保 正美		
11	受取方法 Method of receipt	1. Receive via company ⇒ Sign the power of attorney field. 2. Transfer to personal account ⇒ Enter the receipt information for funds transfer.		
12	委任状 Power of attorney	本請求に基づく給付金に関する受領を事業所に委任します I hereby authorize the above company to receive the benefit based on this application. Year Month Date 健保 正美 被保険者氏名 Name of insured person		
13	振込先 Bank code Bank name Branch code	銀行	支店	1. 普通 口座番号 2. 当座 Account no.

Notes

- Payment date and payment method
  - If the form is received by the health insurance association by the 20th of the month, payment will be made on the 15th of the following month. (The payment date is moved forward if the 15th falls on a weekend or holiday.) However, depending on the contents of the application, the health insurance association might need more time to review it, delaying payment by one or more months. (Some offices might set their own deadlines.)
  - The available payment options are (1) Direct payment from the health insurance association and (2) Payment via office with salary payment. You can find out more by contacting the person in charge of health insurance in your office (company).
- Sending a notice of payment decision
  - When the insurer decides to pay the claim, a notice will be sent to the contact address provided on the application form on around the 10th of the month in which the benefit will be paid. Please note that we are unable to reissue this notice.

Deposit type  
1. General / ordinary (Japan Post Bank ordinary / savings)  
2. Current account

Use this form to claim injury or sickness allowance when all of the following conditions are met:

- The subject is recuperating from an illness or injury suffered off the job
  - The subject is unable to work while recuperating
  - The subject has had four or more consecutive days off work (including weekends and holidays)
  - The subject is not being paid their salary (or if they are, the amount is less than the injury or sickness allowance)
- Before submitting your first claim, check with the person responsible for health insurance at your office (company) or the health insurance association.

◆ Application Procedure

- Fill in the name and date of birth of the insured person in the attached form K-035 "Space for doctor's opinion/space for employer certification (for Injury and Sickness Allowance)", and have it certified by a doctor.
- Fill in the fields concerning the insured person in form K-031 "Claim for Injury and Sickness Allowance" (see "How to fill in this form").
- Send forms K-031 and K-035 to the person responsible for health insurance at your office.

◆ How to fill in the form (match the number to the example entry)

- Enter the submission date.
- Enter the contact information of the insured person (the notice of payment decision will be sent to this address).
- Enter the period to which the claim applies (including weekends and holidays).
- Declare whether the insured received any salary during the period to which the claim applies.
- If the answer in ④ is [受けた]Yes, then enter the period and the amount received.
- Declare whether the insured started to receive a disability pension (or disability allowance) while receiving an injury or illness allowance.
- Enter the name of the condition for which the insured received a disability pension.
- Circle [有]Yes if the injury is due to the act of a third party, such as a traffic accident. In this case, let the health insurance association know as soon as possible.
- Circle whether the claim relates to a period for which the insured is receiving compensation for absence from work from their workers' compensation insurance. If you circle [はい]Yes or [請求中]Claim pending, enter the Labor Standards Inspection Office that will make the payment (the office that received the claim).
- If the insured has received an injury or sickness allowance in the past and the current claim relates to the same or related sickness or injury, an inquiry might be made to the doctor or office of the insured. This field is intended to expedite the process by obtaining consent in advance, eliminating the need to submit additional forms. Please fill in this section.
- Select the preferred method of payment.
- If [1. 事業所経由で受け取る]1. Payment via office is preferred, please sign the power of attorney section. Note: Check with the person responsible for health insurance at your office (company) regarding whether the allowance will be paid with salary.
- If [2. 個人の口座へ振り込み]2. Payment to personal account is preferred, then fill in the bank account details. (Note that the account must belong to the claimant. You can also specify accounts that are with JP Bank, credit unions, and agricultural cooperatives).

Note: When correcting the information you entered, draw a double line through the information to be corrected and enter the correct information and the name of the insured person.

◆ Required Attachments

- Attached document K-035 "Space for doctor's opinion/space for employer certification (for Injury and Sickness Allowance)" (Original)
- When receiving a disability pension (or disability allowance)
  - Notification of Pension Transfer (Copy) (pertaining to the period to which the claim relates)  
Note: If the pension amount has been revised for the period to which the claim relates, you must also submit a Notification of Revision of Pension Amount (Copy).
  - The medical certificate submitted as part of the disability pension claim (Copy)  
Note: This is only needed the first time the applicant applies.
  - Notification of Revision of Pension Amount for National Pension and Welfare Annuity Insurance (Copy)  
Note: This is only needed if the pension amount is revised.
- K-053 "Consent Form": This is only needed the first time the applicant applies
- K-052 "Health Insurance Coverage Survey Form (for Injury/Sickness Benefit Claims)": Note that only certain people are required to attach this form. For details, see the example of K-052 "Health Insurance Coverage Survey Form (for Injury/Sickness Benefit Claims)".

◆ Address for Submission

To minimize the chance of documents being lost, we recommend that you use registered mail or similar means. Submit to the person in charge of health insurance in your office (company).

◆ Submission Deadline

Please file the claim within two years of the day following the date of each claim (based on the date on which the form is received by the health insurance association).