

Example

K-032 ()

日立健康保険組合 御中

健康保険 出産手当金請求書 Health Insurance Claim for Maternity Allowance

※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 8 月 1 日	備考	
	被保険者証 記号・番号 Health insurance card code and number	記号 1 0 0 0 0 1 番号 0 0 0 0 0 0 0 0	被保険者名 氏名 Name of insured person	(フリガナ) ケンボ マサミ 健保 正美
2	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.	〇〇〇〇
	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	(Tel: 000-000-0000)
3	出産予定日 Expected date of delivery	令和〇〇年 4 月 5 日	出産日 Date of delivery	令和〇〇年 4 月 10 日
	出産のため休んだ期間 Period off from work for childbirth	令和〇〇年 3 月 1 日から 令和〇〇年 6 月 5 日まで 97日間 Year Month Date Year Month Date days (period)		
4	上記の休んだ期間分の 報酬(賃金)を受けましたか Did you receive any remuneration (wages) for the above period off from work?	受けた Yes	受けない No	
5	報酬の支払を受けたときはその報酬 の額とその支払の基礎となった期間 amount thereof and period on which the remuneration was based	(From) 令和 年 月 日 から 令和 年 月 日まで Year Month Date Year Month Date	の分として 円 yen	
6	受取方法 Receive via	① 事業所経由で受け取る ⇒委任状欄にご署名ください ② 個人の口座へ振り込み ⇒振込先を記入してください ③ 受取先を指定する ⇒委任状欄にご署名ください		
7	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. 令和 年 月 日 被保険者氏名 Name of insured person		
8	振込先 Bank code	銀行 〇〇〇〇 〇〇 支店 〇〇 〇〇 Bank name Branch code	1. 普通 2. 当座	口座 番号 〇〇〇〇 〇〇〇〇 〇〇〇〇 〇〇〇〇

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

Notes

- ① 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).
- ② 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.

Use this application form in the following circumstances:

When the insured person takes time off work (such as maternity leave) due to childbirth and is unpaid for that period
(Or if paid, the payment is less than the maternity allowance)

◆ Application Procedure

- ① In the attached form K-036 (Space for doctor's opinion/space for employer certification (for Claim for Maternity Allowance)), fill in the name and date of birth of the insured person and obtain the certification of a doctor or midwife.
- ② Fill in the Information About Insured Person fields of the K-032 Claim for Maternity Allowance form (see "How to fill in this form")
- ③ Submit K-032 and K-036 to the person responsible for health insurance at your office (company).

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

- ① Enter the submission date.
- ② Enter the contact information of the insured person (the notice of payment decision will be sent to this address).
- ③ Enter the period in which the insured person took leave (such as maternity leave).
- ④ Indicate whether you have been paid during the period to which this application applies.
- ⑤ If you circled [受けた]Yes in ④, enter the period and amount.
- ⑥ Select the preferred method of payment.
- ⑦ 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.
- ⑧ 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

K-036 (Space for doctor's opinion/space for employer certification (for Claim for Maternity Allowance)) (Original)

◆ 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).