For those who have Private Health Insurance

2013 edition
Ministry of Health, Labour and Welfare, Japan
Hiroshima Prefecture

To Overseas Atomic Bomb Survivors
- Procedures for the Medical Expense Support Program for Overseas Atomic Bomb Survivors -

(* This notice is for those living in the following countries: Brazil, Argentina, Republic of Paraguay, Republic of Bolivia and Republic of Peru.)

Receiving of applications for the Medical Expense Support for 2013 has started. Those who have been issued Notification of the Confirmation of Eligibility could follow the procedures below for application.

1. Please submit the following papers (1)-(6).

(1) Application Form

Please complete the necessary information in the formats provided on pages 4-7 of this notice.

(2) A governmental certificate verifying identity (This should be received within one month of issue.)

e.g., one of the followings: a family register, an abstract of the family register, an attestation by a notary public, a certificate of residence, or evidence of residency, etc.

* However, if you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at the time of submitting the Application Form, it is not necessary to submit any one of these certificates.

(3) A copy of whichever of the following documents:

a) Notification of the Confirmation of Eligibility
b) Atomic Bomb Survivor's Certificates
c) Statements of Recognition for Situation with regard to Atomic Bombing (Atomic Bomb Survivor Statements of Recognition)

* If any of the information, including your name, address or telephone number, has since changed, please submit the form provided on page 8 (Notification of Change(s) in Confirmed

Information) with the required information.

(4) A document confirming the bank account into which funds will be transferred, such as a photocopy of a bank book, etc.

(5) A copy of the contract of concerned insurance
* The "concerned insurance" refers to the medical insurance by which you are protected from January to December 2013.

(6) Receipts of premiums you paid to the insurance company

(Note) The receipt from the insurance company must specify the following four points.

1) Amount paid to the insurance company

2) Name of the payer (it should be identical to the name of applicant)

3) Name, address, and telephone number of the insurance company

4) Date of the payment to the insurance company

* Please make the amount of paid premiums clear by suitable means such as by underlining. If submitted receipts include medical premiums for person(s) other than the applicant, please make payment for the applicant clear in a similar way.
* With regard to the receipt, please make sure to submit original one (copy unacceptable). (A copy may be accepted if there are special reasons.)

2. The "Medical Expense Support for 2013" covers medical premiums paid to the insurance company during the 12 months from January to December 2013. The limit on reimbursements for that year is 179,000 yen (or 191,000 yen in the case where there are good reasons for excess).

3. These papers ((1)-(6) of item 1) mentioned above should be mailed **so that they arrive at the following address no later than January 31 (Friday), 2014**.

If the paid premiums reach the limit of reimbursement, 179,000 yen (or 191,000 yen in the case where there are good reasons for excess), you may send the papers at that time.

The transfer procedures for the Medical Expense Supports will have been implemented by **March 31, 2014**. Please make sure to contact us if you change your bank account before that time.

4 Before mailing, please make sure that all of the above mentioned papers necessary for application are enclosed by using the checklist provided on page 9.

If you have any questions, please feel free to contact the below.

Hosoda
Japan Public Health Association
Tel: +81-3-3352-4281
Fax: +81-3-3352-4605
E-mail: zaigai@jpha.or.jp

[Address]
Medical Expense Support Program for Overseas Atomic Bomb Survivors
Japan Public Health Association
1-29-8, Shinjuku, Shinjuku-ku, Tokyo 160-0022, Japan

Application Form for Support Program (Medical Premiums)

Notification number of the confirmation of eligibility for Medical Expense Support			-
Name		Date of birth (M/D/Y)	Sex: Male/Female
Country of residence			
Address			
Telephone number	(Start from country code)		
Fax / E-mail			
Bank account for transfer	Name of financial institution		
	Branch name (* 1)		
	Branch address (* 2)		
	Account No. (* 3)		
	Name of account holder (* 4)		
Receipt or non-receipt of any allowance at the time of the application (*5)		Receipt / Non-receipt	
Amount of grants applied for	In local currency:	(unit) (* For official use only)	
	In Japanese yen:	Yen value (* For official use only)	

* 1 Please make sure that the name of the branch is filled in.
* 2 Please be sure to fill in the address of the branch.
* 3 Attach papers which confirm the bank account for transfer, such as a copy of a bankbook, etc.
* 4 Bank accounts must be in the name of the person possessing eligibility.
* 5 If you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at the time of this application, please check "Receipt".

Governor of Hiroshima Prefecture

I hereby apply for the Medical Expense Support for 2013 with the related documents attached.

Date: ___/___/___(M/D/Y)

Name of applicant:
Seal (Signature)

(If you apply on behalf of the applicant, please fill in here.)

Name of proxy applicant:

Proxy applicant contact details:

* Please provide the details on which you can be reached during office hours.

Details of Grants Applied for (Payment by Monthly Installment)

	Amount	Remarks
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		
Total		

Note 1: Paste receipts of premiums to page 7 (categorize receipts by month).

Note 2: Write amounts in the monetary unit of the country of residence.

○ For the following items, please circle the appropriate number.

- Insured unit

  1) Individual, 2) Couple, 3) Family (with members), 4) Other (with members)

- Monthly premium payment unit

  1) Paid by an individual, 2) Paid on a couple basis, 3) Paid on a family basis,

  4) Other (please specify:)

Details of Grants Applied for (Payment other than by Monthly Installment)

Amount	Period of premiums you paid for
	From ___(M)/___(D)/___(Y) to ___(M)/___(D)/___(Y)
	From ___(M)/___(D)/___(Y) to ___(M)/___(D)/___(Y)
	From ___(M)/___(D)/___(Y) to ___(M)/___(D)/___(Y)
	From ___(M)/___(D)/___(Y) to ___(M)/___(D)/___(Y)
	From ___(M)/___(D)/___(Y) to ___(M)/___(D)/___(Y)
	From ___(M)/___(D)/___(Y) to ___(M)/___(D)/___(Y)

Note 1: The "Period of premiums you paid for" refers to the period during which you are protected by that insurance with your paid premiums. Write the period by stating the starting and ending date (M/D/Y).

Note 2: Write amounts in the monetary unit of the country of residence.

○ For the following items, please circle the appropriate number.

- Insured unit

  1) Individual, 2) Couple, 3) Family (with members), 4) Other (with members)

- Monthly premium payment unit

  1) Paid by an individual, 2) Paid on a couple basis, 3) Paid on a family basis,

  4) Other (please specify:)

Attached Receipts for the Month of ( )

Note 1: Receipts must have the following:

(1) Amount paid to the insurance company

(2) Name of the payer (it should be identical to the name of applicant)

(3) Name, address, and telephone number of the insurance company

(4) Date of the payment to the company

Note 2: Please photocopy this form and prepare one for each month, as necessary. Submission in other formats is acceptable as long as the months are clearly stated.

Notification of Change(s) in Confirmed Information
(Change in Name, Address and/or Telephone number)

Date: ___/___/___ (M/D/Y)

Governor of Hiroshima Prefecture

(New) Address:
(New) Name: Seal (Signature)

I hereby notify the change(s) in the name, address and/or telephone number as follows with an attached copy of the Notification of the Confirmation of Eligibility for Medical Expense Support.

Notification number of the confirmation of eligibility for Medical Expense Support				-					
Change in name	Former name								
	New name								
Change in address	Former address								
	New address								
Change in telephone number	Former number	(Start from country code)							
	New number	(Start from country code)							
Date of the change(s)		(M/D/Y)							

* Documents confirming the change(s) specified above and the identity of the individual in question should also be attached.

Checklist for Documents to be Submitted

* Before submitting documents, please make sure that all of necessary documents are enclosed by using this checklist.

Enclosed or not	Documents to be submitted
☐	Application Form (page 4)
☐	Details of Grants Applied for (page 5 or 6)
☐	Governmental certificate verifying identity: Be sure to prepare the one received within one month of issue (a family register, an abstract of the family register, an attestation by a notary public, a certificate of residence, or evidence of residency, etc.) * If you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at the time of submitting the Application Form, it is not necessary to submit any one of these certificates.
☐	Copy of one of the following: Notification of the confirmation of eligibility, Atomic Bomb Survivor's Certificates, Statements of Recognition for Situation with regard to Atomic Bombing (Atomic Bomb Survivor Statements of Recognition)
☐	Document confirming the bank account into which funds will be transferred, such as a photocopy of a bank book, etc.
☐	Copy of the contract of concerned insurance
☐	Receipts of premiums you paid to the insurance company (attached to the form of "Attached Receipts for the Month of" on page 7) *1: Please make the amount of paid premiums clear by suitable means such as by underlining. *2: If submitted receipts include medical premiums for person(s) other than the applicant, please make payment for the applicant clear.
☐	Notification of change(s) in confirmed information (only when you have changed your address (page 8))