Information on Applying for Medical Expense Benefits, etc.

Novemer 2017
Ministry of Health, Labour and Welfare
Hiroshima Prefecture

[* This notice is for residents of Brazil, Argentina, Paraguay, Bolivia, Peru, Uruguay and Venezuela.]

Beginning in January 2016, people residing outside Japan can receive benefits under the Atomic Bomb Survivors' Assistance Act (hereinafter "the Act") for out-of-pocket medical expenses incurred in one's country of residence.

Accordingly, because it is now possible to apply for Medical Expense Benefits under the Act in addition to applying for Medical Expense Support as was possible before, information on the application methods for each are provided below.

1. Simplified Application with Receipts, etc. (Application for Medical Expense Support)

You may use receipts or other such documentation in simplified procedures to receive benefits <u>with a ceiling maximum* of 300,000 yen a year</u> as Medical Expense Support.

* The table on page 2 shows the provision ceiling converted into the currencies used in countries of residence. With regard to medical expenses paid during the one-year period from January to December 2017, an application for Medical Expense Support can be filed within the scope provided under "Medical Expense Support ceiling."
* Support payments are made in the currency of the country of residence. When making the payment, the amount will be affected by the exchange rate depending on the target currency. Please note that there may be some fluctuation to the “300,000 yen” support ceiling stated in this information when receiving the payment into a yen bank account.

Medical Expense Support Ceilings for Currencies Used in Countries of Residence (Medical payments, etc. made in the one-year period from January through December 2017)			
Country/region	Currency unit	Medical Expense Support ceiling	
Republic of Argentina	Argentine peso	39,063	ARS
Commonwealth of Australia	Australian dollar	3,427	AUD
Plurinational State of Bolivia	boliviano	17,493	BOB
Federative Republic of Brazil	real	7,966	BRL
Kingdom of Cambodia	riel	10,830,325	KHR
Canada	Canadian dollar	3,520	CAD
People's Republic of China	renminbi	18,171	CNY
EU	euro	2,495	EUR
Hong Kong	Hong Kong dollar	20,325	HKD
Republic of Indonesia	rupiah	31,578,947	IDR
Malaysia	ringgit	11,198	MYR
United Mexican States	peso	43,103	MXN
Kingdom of Morocco	Moroccan dirham	25,554	MAD
New Zealand	New Zealand dollar	3,722	NZD
Republic of Peru	sol	8,251	PEN
Commonwealth of the Philippines	Philippine peso	127,119	PHP
Bolivarian Republic of Venezuela	bolivar fuerte	27,003	VEF
Kingdom of Saudi Arabia	Saudi riyal	9,839	SAR
Republic of Singapore	Singapore dollar	3,724	SGD
Kingdom of Sweden	Swedish krona	23,364	SEK
Swiss Confederation	Swiss franc	2,677	CHF
Taiwan	new Taiwan dollar	79,156	TWD
Kingdom of Thailand	baht	90,361	THB
United Kingdom	UK pound	2,089	GBP
United States of America	US dollar	2,670	USD
Oriental Republic of Uruguay	Uruguayan peso	77,121	UYU
Socialist Republic of Vietnam	dong	57,692,308	VND

* Based on currency exchange rates at the beginning of April 2017

* If you have any questions, please inquire with the Japan Public Health Association.

(1) Eligible persons

○ Persons who have paid for out-of-pocket medical expenses in their country of residence

○ Surviving family members acting as a proxy for an eligible person in the event that said eligible person is deceased

(2) Qualifying medical expenses, etc.

Benefits of up to 300,000 yen per year are available for the following expenses.

○ Payments made in the one-year period from January through December 2017

-Insurance fees paid to an insurance company and out-of-pocket medical expenses

- Expenses for medical examinations

*** You cannot apply for benefits for both insurance fees and medical expenses.**

(3) Applying for Medical Expense Benefits under the Act

○ If you have applied for insurance fee benefits and you pay for medical expenses out-of-pocket, you may apply for Medical Expense Benefits under the Act as described on page 4.

○ For out-of-pocket medical expenses exceeding an amount of 300,000 yen, under the Act you may apply for medical expense benefits as described on page 3.

* If you apply for Medical Expense Benefits under the Act, you are required to submit documentation including a written diagnosis and observations by a physician which has been issued by a medical institution or pharmacy and which provides details concerning the name of the disease and the nature of the treatment.

(4) Other information

Please be aware that the deadline is Wednesday, January 31, 2018.

Until the final deadline, applications may be filed any number of times up to the provision ceiling of 300,000 yen.

Please also be aware that applications are reviewed in accepted order, and it takes a while for applicants to receive the benefit since the review requires a certain amount of time.

(5) Application procedures

Application for insurance fee benefits: Please refer to the yellow form.

Application for medical expense benefits: Please refer to the blue form.

2. Applying If the Amount Exceeds 300,000 yen, etc. (Applying for Medical Expense Benefits under the Act)

Under the Act, you may file an application for out-of-pocket costs in excess of 300,000 yen. Furthermore, if you have applied for insurance fee benefits and you pay for medical expenses out-of-pocket, you may apply for Medical Expense Benefits under the Act.

(1) Eligible persons

- ○ Recipients of benefits for insurance fees through the Medical Expense Support Program
- ○ Persons with out-of-pocket expenses exceeding the ceiling for Medical Expense Support (300,000 yen)
- ○ Surviving family members acting as a proxy for an eligible person in the event that said eligible person is deceased

(2) Qualifying medical expenses

Out-of-pocket medical expenses

* However, the following medical expenses do not qualify for benefits.

1. Premium room charges at the time of admission, certification issuance processing fees, and other expenses not recognized as relating to medical

treatment under Japan's public health insurance

2. Implants, advanced medical care and other treatment not covered by Japan's public health insurance
3. Treatment for which support under the Medical Expense Support Program has already been received, etc.

Main Items Not Covered by Japan's Public Health Insurance
○ Expenses not recognized as relating to medical treatment
- Premium room charges at time of admission
- Hospital gown fees, diaper fees
- Document fees, certification issuance processing fees
○ Medical treatment, assistive equipment and other fees not qualifying for benefits
- Implant treatment expenses
- Drug or supplement expenses incurred without a prescription
- Expenses for medical exams that deviate from the purpose of treatment
- Eyeglasses and hearing aids
- Vaccinations
- Advanced medical treatment, etc.

(3) Other information

○ Recipients of benefits for insurance fees:

You may apply for out-of-pocket Medical Expense Benefits under the Act.

○ Persons with out-of-pocket expenses exceeding the ceiling for Medical Expense Support (300,000 yen)

An application can be made under the Act even if the amount does not exceed the 300,000 yen ceiling, but the procedures become complicated by the requirement for such documentation as a written diagnosis and observations by a physician which indicates the name of the disease and the nature of the treatment. In addition, the review requires considerable time to calculate the cost of similar treatment provided in Japan.

Therefore, please be aware that an application in accordance with the Act will take considerable time until

benefits are issued when compared to Simplified Application with Receipts.

For out-of-pocket expenses of up to 300,000 yen, please consider applying for Simplified Application with Receipts, as described on page 1.

○If you make an application in accordance with the Act by submitting the required documentation for each of the time periods below, following a review, you may receive a benefit (to cover your out-of-pocket).

- A period from 2004 onward during which Medical Expense Support benefits were not received
- A period between acquisition of an atomic bomb survivor's health handbook and 2003

(4) Application procedures

Please refer to the pink form.

Medical Expense Benefits for Overseas Atomic Bomb Survivors

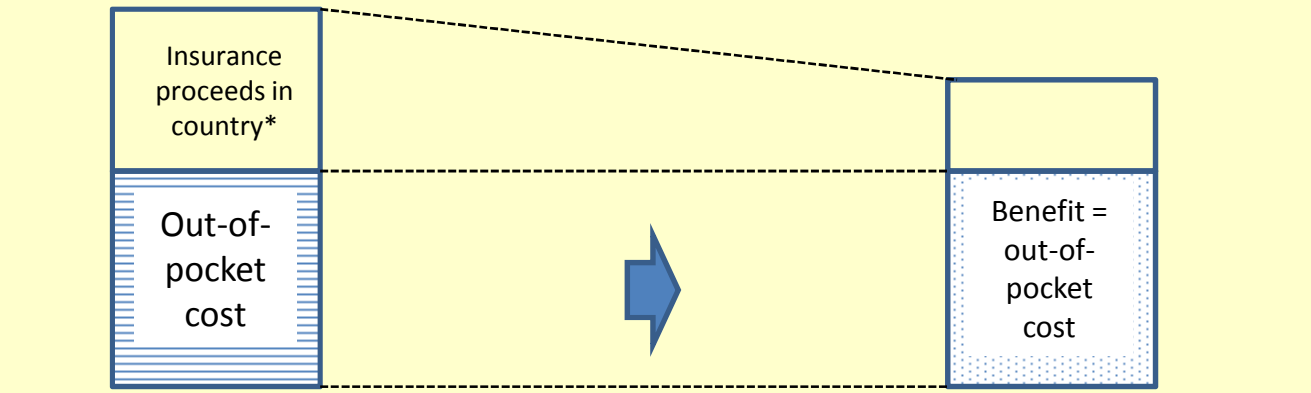
(Ref)

Calculation Method

1. If in-country care is similar to care in Japan and calculated cost exceeds out-of-pocket cost

⇒ **Benefit for out-of-pocket cost**

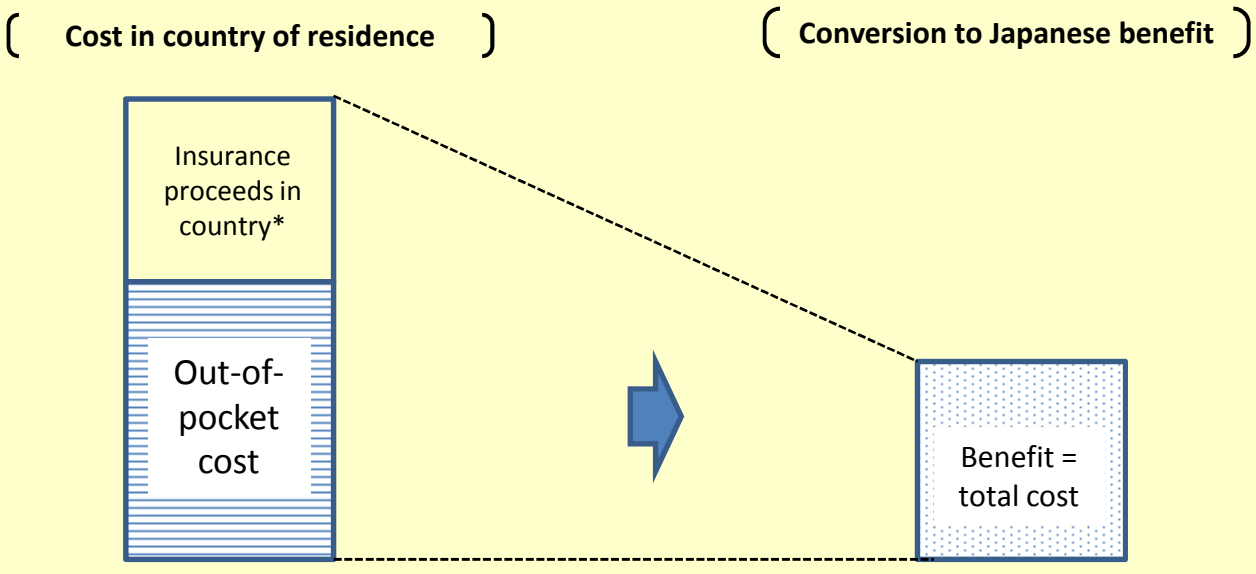
* Because the cost when converted to the Japanese benefit exceeds out-of-pocket cost, the benefit matches the out-of-pocket cost.



2. If in-country care is much more expensive than care in Japan

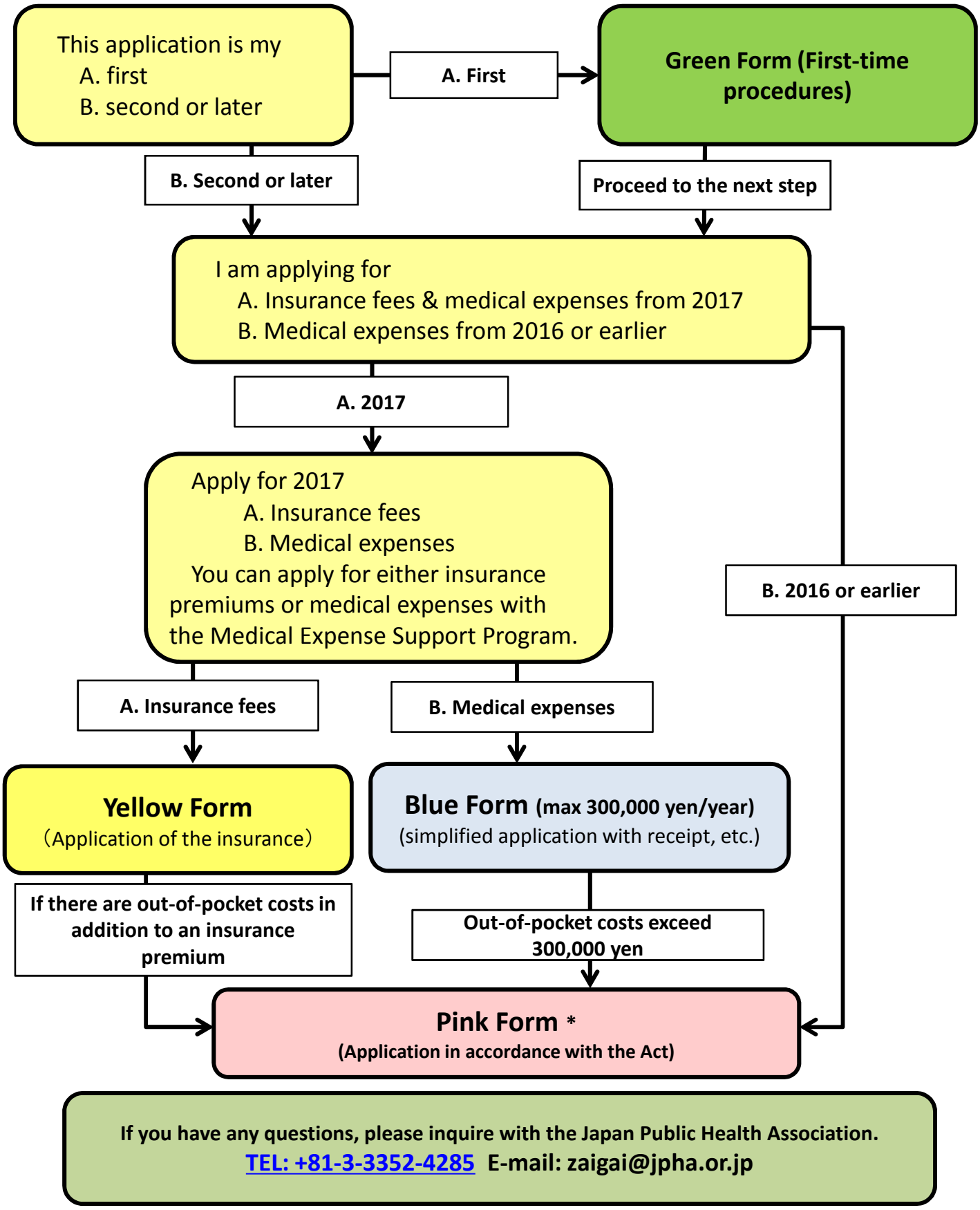
⇒ **Full benefit equal to converted Japanese benefit**

* However, out-of-pocket cost exceeds benefit amount.



* Includes public insurance proceeds, private insurance proceeds and other proceeds for medical care.

Selecting an Application: Check This Flowchart



If you have any questions, please inquire with the Japan Public Health Association.
TEL: +81-3-3352-4285 E-mail: zaigai@jpha.or.jp

*** The pink form can be used to file an application even if the amount does not exceed the provision ceiling of 300,000 yen, but the procedures will be complex.**

Simplified Application with a Receipt, etc. (Insurance Fees)

(Medical Expense Support Program [Insurance fee] : Application Procedures)

◆DOCUMENTS TO SUBMIT

Submit the following documents for all qualifying insurance fee. When submitting, please check that you have the required documents on the checklist on page 3.

1. Application Form for Medical Expense Support (Insurance Fees) (page 4, Form number 1)
2. Benefit application monthly breakdown (page 5, Form number 1-2)
3. Insurance fee receipt
4. Copy of insurance policy
5. Documents verifying identity
6. A copy of one of the followings: Notification of the Confirmation of Eligibility; Atomic Bomb Survivor's Health Handbook; Statements of Recognitions for situation with regard to Atomic bombing.
7. Documents confirming account to receive transfer

In addition to documents 1-7 listed above, applicants meeting the conditions below should also asked to submit the following documentation.

(If your home address or other details concerning notification have changed)

8. Notification of Change(s) in Confirmed Information (page 8, Form number 2)

(If a surviving family member applies for medical expense benefits, etc. for a deceased atomic bomb survivor)

9. Application Form for Medical Expense Support (Insurance Fees) (for application after death) (page 9, Form number 3)
   * Submit 9 in place of 1.
10. Death Notification Form (page 10, Form number 4)
11. Documentation proving family relationship

◆WHEN TO SUBMIT YOUR APPLICATION FORM

Please be aware that the deadline is **Wednesday, January 31, 2018**.

Until the final deadline, applications may be filed any number of times up to the provision ceiling of 300,000 yen.

Please also be aware that applications are reviewed in accepted order, and it takes a while for applicants to receive the benefit since the review requires a certain amount of time.

Submit to:

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

Cut along the dotted line to use this as a label when you send your documents.

If you expect to file multiple applications, make copies in advance of the forms on pages 4 to 10 (copies on white paper are equally valid) and use these, or contact the Japan Public Health Association (see contact information as above) and ask for additional application forms.

Document Submission Checklist (Insurance Fees)

(For simplified payment application procedures with a receipt, etc.)

* Before you submit your documents, please check whether you have the required documents on this checklist.

Check	No.	Documents to Submit
□	1	Application Form for Medical Expense Support (Insurance Fees) (Form number 1)
□	2	Benefit application monthly breakdown If monthly payments: Form number1-2 If other than monthly payments: Form number1-3
□	3	Insurance fee receipt * Please submit receipts bearing the following four pieces of information. - Amount paid - Name of the payer (same name as the applicant's) If the receipt contains medical expenses or the like for a person other than the applicant, only underline the portion that pertains to the applicant. - Name, address and phone number of insurance company. - Date of payment
□	4	Copy of insurance policy * This is medical insurance whose term of coverage includes the period from January to December 2017.
□	5	Documents verifying identity (issued within 1 month prior to application date) (certified copy or extract of family register, certificate by a notary public, residence permit, residence certificate, etc.) * Recipients of Healthcare Allowance, Health Allowance, Special Medical Care Allowance or Special Allowance are not required.
□	6	A copy of one of the following: Notification of the Confirmation of Eligibility; Atomic Bomb Survivor's Health Handbook; Statements of Recognition for situation with regard to Atomic Bombing
□	7	Documents confirming account to receive transfer (copy of a passbook, check, etc.)

Please submit the following documents as necessary.

□	8	Notification of Change(s) in Confirmed Information(Change in Name, Address and/or Telephone Number) (Form number 2) * Please only submit if there are changes to your home address, etc.
□	9	Application Form for Medical Expense Support (Insurance Fees) (for application after death) (Form number 3) * Submit 9 in place of 1.
□	10	Death Notification Form (Form number 4)
□	11	Documentation proving family relationship * Only submit documents 9 through 11 if a surviving family member of a deceased atomic bomb survivor is applying for medical expense benefits.

* First-time applicants should view the information in green and submit documents for first-time registration as well.

Form number 1

Application Form for Medical Expense Support (Insurance Fees)

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	(Begin with country code)			
Fax / E-mail				
Bank account for transfer	Name of financial institution			
	Branch name			
	Branch address			
	Account No.			
	Name of account holder			
Receipt or non-receipt of any allowance at the application		Receipt / Non-receipt		
Amount of grants applied for	In local currency:		(unit))	

* Attach papers which confirm the bank account for transfer, such as a photocopy of a bank book, etc.
* Bank accounts must be in the name of the applicant.
* If you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, or Special Allowance at this application, please check “Receipt”.

I hereby apply for the Medical Expense Support for 2017 with the related documents attached.

Date: / / (M/D/Y)

Name of applicant: Seal (Signature)

*** The applicant must be the person to sign this form.**

(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.

Governor of Hiroshima Prefecture

Form number 1-2

Benefit Application Monthly Breakdown (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) (Form number1-4).
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:)

Form number 1-3

Benefit application monthly breakdown (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)

- Insurance premium payment method

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

  4) Other (please specify:)

Form number 1-4

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 insurance company

Note 2: Any receipts submitted will not be returned.

Note 3: 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.

Form Number 2

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)

_____

*** The applicant must be the person to sign this form.**

Only fill out the items that have changed.

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.

* This notification is for filing an application for the Medical Expense Support Program. There are separate procedures for the local administration that issued the atomic bomb survivor's handbook.

Form Number 3

Application Form for Medical Expense Support (Insurance Fees) (For application after death)

1. Please enter information for the atomic bomb survivor to whom the application pertains.

Notification number of the confirmation of eligibility for Medical Expense Support				–						
Name		Date of birth (M/D/Y)			Sex: Male/ Female					
Address										

2. Please enter information pertaining to the applicant.

Name		Relationship with the atomic bomb survivor	
Country of residence			
Address			
Telephone number	(Start from country code)		
Fax / E-mail			
Bank account for transfer	Name of financial institution		
	Brunch name		
	Account No.		
	Name of account holder		
Amount of grants applied for	In local currency (unit)		

* Attach papers which confirm the bank account for transfer, such as a photocopy of a bank book, etc.
* Bank accounts must be in the name of the applicant.
* Attach papers certifying that the applicant is the legal heir/heiress of the deceased.

I hereby apply for the Medical Expense Support for the year of 2017 for the deceased _____ with the related documents attached.
Should any dispute arise regarding the medical reimbursement already received, I will not accuse the governor of Hiroshima Prefecture for that and will undertake the full responsibility for that.

Date: / / (M/D/Y)

Name of applicant Seal (Signature)

_____

*** The applicant must be the person to sign this form.**

Governor of Hiroshima Prefecture

Form Number 4

Death Notification Form

Date: / / (M/D/Y)

Governor of Hiroshima Prefecture

I hereby notify the death of the eligible person with related documents attached.

Name		Relationship with the atomic bomb survivor	
Country of residence			
Address			
Telephone Number	(Start from country code)		

Deceased	Notification number of the confirmation of eligibility for Medical Expense Support				−					
	Name									
	Last address									
	Date of death									

* Attach papers confirming the date of death of the deceased.
* His/her Notification of the Confirmation of Eligibility should be returned to us.
* This notification is for filing an application for the Medical Expense Support Program. There are separate procedures for the local administration that issued the atomic bomb survivor's handbook.

Simplified Application with Receipts, etc. (Medical Expenses)

(Medical Expense Support Program [Medical Expenses] :Application Procedures)

◆DOCUMENTS TO SUBMIT

Submit the following documents for all qualifying medical expenses and the like. When submitting, please check that you have the required documents on the checklist on page 3.

1. Application Form for Medical Expense Support (Medical)) (page 4, Form number 1)
2. Benefit application monthly breakdown (page 5, Form number 1-2)
3. Receipt or other document proving out-of-pocket cost
4. Documents verifying identity
5. A copy of one of the followings: Notification of the Confirmation of Eligibility; Atomic Bomb Survivor's Health Handbook; Statements of Recognition for situation with regard to Atomic Bombing
6. Documents confirming account to receive transfer
7. Notification of Change(s) in Confirmed Information (Change in Medical Institutions to be Visited) (page 7, Form number 2)

In addition to documents 1-7 listed above, applicants meeting the conditions below are also asked to submit the following documentation.

(If your home address or other details concerning notification have changed)

8. Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number) (page 8, Form number 3)

(If a surviving family member applies for medical expense benefits, etc. for a deceased atomic bomb survivor)

9. Application Form for Medical Expense Support (Medical)) (for application after death) (page 9, Form number 4)
   * Submit 9 in place of 1.
10. Death Notification Form (page 9, Form number 5)
11. Documentation proving family relationship

◆WHEN TO SUBMIT YOUR APPLICATION FORM

Please be aware that the deadline is **Wednesday, January 31, 2018**.

Until the final deadline, applications may be filed any number of times up to the provision ceiling of 300,000 yen.

Please also be aware that applications are reviewed in accepted order, and it takes a while for applicants to receive the benefit since the review requires a certain amount of time.

Submit to:

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

Cut along the dotted line to use this as a label when you send your documents.

If you expect to file multiple applications, make copies in advance of the forms on pages 4 to 10 (copies on white paper are equally valid) and use these, or contact the Japan Public Health Association (see contact information above) and ask for additional application forms.

Document Submission Checklist (Medical)
(Simplified Application with Receipts, etc.)

* Before you submit your documents, please check whether you have the required documents on this checklist.

Check	No.	Documents to Submit
□	1	Application Form for Medical Expense Support (Medical)) (Form number1)
□	2	Benefit Application Monthly Breakdown (Form number 1-2)
□	3	Receipt or other document confirming out-of-pocket cost *1 Please submit receipts bearing the following four pieces of information. - Amount paid - Name of person receiving medical treatment (same name as the applicant's) If the receipt contains medical expenses or the like for a person other than the applicant, only underline the portion that pertains to the applicant. - Medical institution's name, address and phone number - Date of payment *2 Please send the following documents as necessary. If drugs were purchased at a pharmacy with a doctor's prescription: the prescription If proceeds received from private insurance: certification of insurance proceeds, etc.
□	4	Documents verifying identity (issued within 1 month prior to application date) (certified copy or extract of family register, certificate by a notary public, residence permit, residence certificate, etc.) * Recipients of Healthcare Allowance, Health Allowance, Special Medical Care Allowance or Special Allowance are not required.
□	5	A copy of one of the following: Notification of the Confirmation of Eligibility; Atomic Bomb Survivor's Health Handbook; Statements of Recognition for situation with regard to Atomic Bombing
□	6	Documents confirming account to receive transfer (copy of a passbook, check, etc.)
□	7	Notification of Change(s) in Confirmed Information (Change in Medical Institutions to be Visited) (Form number 2)

Please submit the following documents as necessary.

□	8	Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number) (Form number 3) * Please only submit if there are changes to your home address, etc.
□	9	Application Form for Medical Expense Support (Medical)) (for application after death) (Form number 4) * Submit 9 in place of 1.
□	10	Death Notification Form (Form number 5)
□	11	Documentation proving family relationship * Only submit documents 9 through 11 if a surviving family member of a deceased atomic bomb survivor is applying for medical expense benefits.

* First-time applicants should view the information in green and submit documents for first-time registration as well.

Form number 1

Application Form for Medical Expense Support (Medical)

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	(Begin with country code)			
Fax / E-mail				
Bank account for transfer	Name of financial institution			
	Branch name			
	Branch address			
	Account No.			
	Name of account holder			
Receipt or non-receipt of any allowance at the application		Receipt / Non-receipt		
Amount of grants applied for	In local currency:		(unit))	

* Attach papers which confirm the bank account for transfer, such as a photocopy of a bank book, etc.
* Bank accounts must be in the name of the applicant.
* If you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, or Special Allowance at this application, please check “Receipt”.

I hereby apply for the Medical Expense Support for 2017 with the related documents attached.

Date: / / (M/D/Y)

Name of applicant: Seal (Signature)

*** The applicant must be the person to sign this form**

(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.

Governor of Hiroshima Prefecture

Form number 1-2

Benefit Application Monthly Breakdown

	Amount	Remarks (Name of hospital in case of hospitalization)
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		
Total		

Note 1: Paste receipts of expenses to Page 6 (categorize receipts by month) (Form number 1-3).
Note 2: Write amounts in the monetary unit of the country of residence.

Form number 1-3

Attached Receipts for the Month of ( )

Note 1: Receipts must have the following:

(1) Amount paid to the medical institution

(2) Name of person receiving medical treatment (it should be identical to the name of applicant)

(3) Name, address, and telephone number of the medical institution

(4) Date of the payment

Note 2: Any receipts submitted will not be returned.

Note 3: 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.

Form number 2

Notification of Change(s) in Confirmed Information (Change in Medical Institutions to be Visited)

Date: / / (M/D/Y)

Governor of Hiroshima Prefecture

Country of residence

Address:

Name:

Telephone Number (Start from country code)

Name of medical institutions	Address of medical institutions	Telephone Number (Start from country code)

Form Number 3

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)

_____

*** The applicant must be the person to sign this form**

Only fill out the items that have changed.

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.

* This notification is for filing an application for the Medical Expense Support Program. There are separate procedures for the local administration that issued the atomic bomb survivor's handbook.

Form Number 4

Application Form for Medical Expense Support (For application after death)

1. Please enter information for the atomic bomb survivor to whom the application pertains.

Notification number of the confirmation of eligibility for Medical Expense Support				–					
Name		Date of birth (M/D/Y)			Sex: Male/ Female				
Address									

2. Please enter information pertaining to the applicant.

Name		Relationship with the atomic bomb survivor	
Country of residence			
Address			
Telephone number	(Start from country code)		
Fax / E-mail			
Bank account for transfer	Name of financial institution		
	Brunch name		
	Branch address		
	Account No.		
	Name of account holder		
Amount of grants applied for	In local currency (unit)		

* Attach papers which confirm the bank account for transfer, such as a photocopy of a bank book, etc.
* Bank accounts must be in the name of the applicant.
* Attach papers certifying that the applicant is the legal heir/heiress of the deceased.

I hereby apply for the Medical Expense Support for the year of 2017 for the deceased _____ with the related documents attached.
Should any dispute arise regarding the medical reimbursement already received, I will not accuse the governor of Hiroshima Prefecture for that and will undertake the full responsibility for that.

Date: / / (M/D/Y)

Name of applicant Seal (Signature)

_____

*** The applicant must be the person to sign this form**

Governor of Hiroshima Prefecture

Form Number 5

Death Notification Form

Date: / / (M/D/Y)

Governor of Hiroshima Prefecture

I hereby notify the death of the eligible person with related documents attached.

Name		Relationship with the atomic bomb survivor	
Country of residence			
Address			
Telephone Number	(Start from country code)		

Deceased	Notification number of the confirmation of eligibility for Medical Expense Support				−					
	Name									
	Last address									
	Date of death									

* Attach papers confirming the date of death of the deceased.

* His/her Notification of the Confirmation of Eligibility should be returned to us.

* This notification is for filing an application for the Medical Expense Support Program. There are separate procedures for the local administration that issued the atomic bomb survivor's handbook.

Application Procedures If Amount Exceeds ¥300,000, etc.
(Medical Expense Benefits under the Act : Application Procedure)

◆DOCUMENTS TO SUBMIT

Submit the following documents for all qualifying medical expenses. When submitting, please check that you have the required documents on the checklist on page 3.

1. Application Form for Medical Expense and General Disease Medical Expense Payment (page 4, Form number 1)
2. Receipt or other document proving out-of-pocket cost
3. Written diagnosis and observations by a physician indicating disease name, nature of treatment, etc.
4. Documents verifying identity
5. Copy of Atomic Bomb Survivor's Health handbook
6. Documents confirming account to receive transfer

In addition to documents 1-6 listed above, applicants meeting the conditions below are also asked to submit the following documentation.

(If receiving a special medical allowance)

7. Copy of certification

(If your home address or other details concerning notification have changed)

8. Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number) (page 5, Form number 2)

(If a surviving family member applies for medical expense benefits for a deceased atomic bomb survivor)

9. Application Form for Medical Expense and General Disease Medical Expense Payment (for application after death) (page 6, Form number 3)
   * Submit 9 in place of 1.
10. Death Notification Form (page 7, Form number 4)
11. Documentation proving family relationship

* You are asked to delegate proxy the Japan Public Health Association to receive medical fee benefits in order to receive the transfer from the JPHA as usual. If you entrust the JPHA, select " Delegate Proxy " in the corresponding box on the application form.

◆WHEN TO SUBMIT YOUR APPLICATION FORM

Reviews and benefit issuance are conducted in the order applications are accepted.

You may apply at any time until five years after the medical expense has been paid.

However, the review requires considerable time to calculate the cost of similar treatment if provided in Japan. Therefore, please be aware that it will take time for you to receive the benefit.

Submit to:

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk
Japan Public Health Association
1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN
Tel: +81-3-3352-4285
Fax: +81-3-3352-4605
Email: zaigai@jpha.or.jp

Cut along the dotted line to use this as a label when you send your documents.

If you expect to file multiple applications, make copies in advance of the forms on pages 4 to 10 (copies on white paper are equally valid) and use these, or contact the Japan Public Health Association (see contact info above) and ask for additional application forms.

Document Submission Checklist

(Application Procedures If Amount Exceeds 300,000 yen, etc.)

* Before you submit your documents, please check whether you have the required documents on this checklist.

Check	No.	Documents to Submit
□	1	Application Form for Medical Expense and General Disease Medical Expense Payment (Form number 1)
□	2	Receipt or other document confirming out-of-pocket cost *1 Please submit receipts bearing the following four pieces of information. - Amount paid - Name of person receiving medical treatment (same name as the applicant's) If the receipt contains medical expenses or the like for a person other than the applicant, only underline the portion that pertains to the applicant. - Medical institution's name, address and phone number - Date of payment *2 Please send the following documents as necessary. If drugs were purchased at a pharmacy with a doctor's prescription: the prescription If proceeds received from private insurance: certification of insurance proceeds, etc.
□	3	Written diagnosis and observations by a physician indicating disease name, nature of treatment, etc.
□	4	Documents verifying identity (issued within 1 month prior to application date) (certified copy or extract of family register, certificate by a notary public, residence permit, residence certificate, etc.) * Recipients of Healthcare Allowance, Health Allowance, Special Medical Care Allowance or Special Allowance are not required.
□	5	Copy of Atomic Bomb Survivor's Health Handbook
□	6	Documents confirming account to receive transfer (copy of a passbook, check, etc.)

Please submit the following documents as necessary.

□	7	Copy of certification of the Authorization of Atomic Bomb Disease * Only submit if receiving a special medical allowance.
□	8	Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number) (Form number 2) * Please only submit if there are changes to your home address, etc.
□	9	Application Form for Medical Expense and General Disease Medical Expense Payment (For application after death) (Form number 3) * Submit 9 in place of 1.
□	10	Death Notification Form (Form number 4)
□	11	Documentation proving family relationship * Only submit documents 9 through 11 if a surviving family member of a deceased atomic bomb survivor is applying for medical expense benefits.

* First-time applicants should view the information in green and submit documents for first-time registration as well.

Form number 1

Application Form for Medical Expense and General Disease Medical Expense Payment

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								
	Branch address								
	Account No.								
	Name of account holder								
Delegate Japan Public Health Association as proxy to receive medical expense (general disease medical expense) payment	Delegate Proxy / Do Not Delegate Proxy								
Certified or not certified as an atomic bomb disease at the application	Certified / Not certified								
Receipt or non-receipt of any allowance at the application	Receipt / Non-receipt								
Amount of grants applied for	In local currency:							(unit))	

* Attach papers which confirm the bank account for transfer, such as a photocopy of a bank book, etc.
* Bank accounts must be in the name of the applicant.
* If you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, or Special Allowance at this application, please check “Receipt”.

I would like to receive the Medical Expense (General Disease Medical Expense) Support through the provisions of Article 17 (Article 18) of the Atomic Bomb Victims' Relief Act, and I hereby submit my application for such with the related documents attached. Furthermore, I delegate the Japan Public Health Association as my proxy to receive this Medical Expense (General Disease Medical Expense) Support.

Date: / / (M/D/Y)

Name of applicant: Seal (Signature)

*** The applicant must be the person to sign this form.**

(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.

Governor of Hiroshima Prefecture

Form Number 2

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)

_____

*** The applicant must be the person to sign this form.**

Only fill out the items that have changed.

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.

* This notification is for filing an application for the Medical Expense Support Program. There are separate procedures for the local administration that issued the atomic bomb survivor's handbook.

Form Number 3

Application Form for Medical Expense and General Disease Medical Expense Payment (For application after death)

1. Please enter information for the atomic bomb survivor to whom the application pertains.

Notification number of the confirmation of eligibility for Medical Expense Support				–					
Name		Date of birth (M/D/Y)			Sex: Male/ Female				
Address									

2. Please enter information pertaining to the applicant.

Name		Relationship with the atomic bomb survivor	
Country of residence			
Address			
Telephone number	(Start from country code)		
Fax / E-mail			
Bank account for transfer	Name of financial institution		
	Brunch name		
	Branch address		
	Account No.		
	Name of account holder		
Delegate Japan Public Health Association as proxy to receive medical expense (general disease medical expense) payment		Delegate Proxy / Do Not Delegate Proxy	
Amount of grants applied for	In local currency (unit)		

* Attach papers which confirm the bank account for transfer, such as a photocopy of a bank book, etc.
* Bank accounts must be in the name of the applicant.
* Attach papers certifying that the applicant is the legal heir/heiress of the deceased.

I would like to receive medical expense benefits (pertaining to medical expenses for general diseases) for the late _____, and I have attached the relevant documentation to apply for this benefit, pursuant to the provision of Article 17 (Article 18) of the Atomic Bomb Survivors' Assistance Act. In addition, I hereby entrust the Japan Public Health Association to receive medical expense benefits (pertaining to medical expenses for general diseases).
I hereby swear that if by any chance a dispute concerning said healthcare expenses arises after the benefit has been received, I shall bear all responsibility and shall not hold the Governor of Hiroshima Prefecture accountable.

Date: / / (M/D/Y)

Name of applicant Seal (Signature)

_____

*** The applicant must be the person to sign this form.**

Governor of Hiroshima Prefecture

Form Number 4

Death Notification Form

Date: / / (M/D/Y)

Governor of Hiroshima Prefecture

I hereby notify the death of the eligible person with related documents attached.

Name		Relationship with the atomic bomb survivor	
Country of residence			
Address			
Telephone Number	(Start from country code)		

Deceased	Notification number of the confirmation of eligibility for Medical Expense Support			–					
	Name								
	Last address								
	Date of death								

* Attach papers confirming the date of death of the deceased.

* His/her Notification of the Confirmation of Eligibility should be returned to us.

* This notification is for filing an application for the Medical Expense Support Program. There are separate procedures for the local administration that issued the atomic bomb survivor's handbook.

Procedures for a First-Time Application

◆REQUIRED DOCUMENT TO SUBMIT

If you are applying for the first time, submit the following document.

- Application Form for Confirmation of Eligibility

◆WHEN TO SUBMIT YOUR APPLICATION FORM

Enclose with your application for medical expense benefits and mail to the following address. The package should be reached **by Wednesday, January 31, 2018**.

Submit to:

ATTN: Overseas Atomic Bomb Survivor Medical Expense Support Program Clerk

Japan Public Health Association

1-29-8 Shinjuku, Shinjuku-ku, Tokyo 160-0022 JAPAN

Tel: +81-3-3352-4285

Fax: +81-3-3352-4605

Email: zaigai@jpha.or.jp

Form number 1

* You must submit this form if you are applying for the first time. Those who are already registered are not required to submit this form.

Application Form for Confirmation of Eligibility

Name		Date of birth (M/D/Y)		Sex: Male/Female
Country of residence				
Address				
Telephone number	(Start from country code)			
Fax / E-mail				
Type	( ) Atomic Bomb Survivor's Certificate ( ) Statements of Recognition for Situation with regard to Atomic Bombing (or Atomic Bomb Survivor Statements of Recognition) *Place a circle in either one.			
Supporting prefecture/city				
Publicly-funded medical expenses recipient No.			-	
Number of the Statements of Recognition for Situation with regard to Atomic Bombing (or the Atomic Bomb Survivor Statements of Recognition)				

I hereby submit the respective documents for the confirmation of eligibility for Medical Expense and General Disease Medical Expense Support.

Date: / / (M/D/Y)

Name of applicant: Seal (Signature)

_____

*** The applicant must be the person to sign this form**

(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.

Governor of Hiroshima Prefecture