Information on Applying for Medical Expense Benefits, etc.

Contents

Application Forms, etc.

○ Application procedure for Medical Expenses Support (insurance premium) <Yellow form>

○ Application procedure for Medical Expenses Support (medical expenses) <Blue form>

○ Application procedure for Medical Expense Benefit under the Act <Pink form>

This information can also be downloaded from the website of the Ministry of Health, Labour and Welfare.

https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/kenkou/genbaku/genbaku02/index.html

QR code

Information on Applying for Medical Expense Benefits, etc.

Introduction

August 2025
Ministry of Health, Labour and Welfare
Hiroshima Prefecture

(This notice is for residents of Brazil, Argentina, Paraguay, Bolivia and Uruguay.)

Japan has the following two systems in place for supporting out-of-pocket medical expenses incurred by atomic bomb survivors residing abroad (in their country of residence). Information on the application methods for each is provided below.

If your annual out-of-pocket expenses

- Are 300,000 yen or less, please use "1. Medical Expenses Support,"
- Exceed 300,000 yen, please apply for "2. Medical Expense Benefits under the Act."*

* Atomic Bomb Survivors' Assistance Act

◎You can apply for "1. Medical Expenses Support" for your annual out-of-pocket expenses up to 300,000 yen and apply for "2. Medical Expense Benefits under the Act" for the portion that exceeds 300,000 yen.

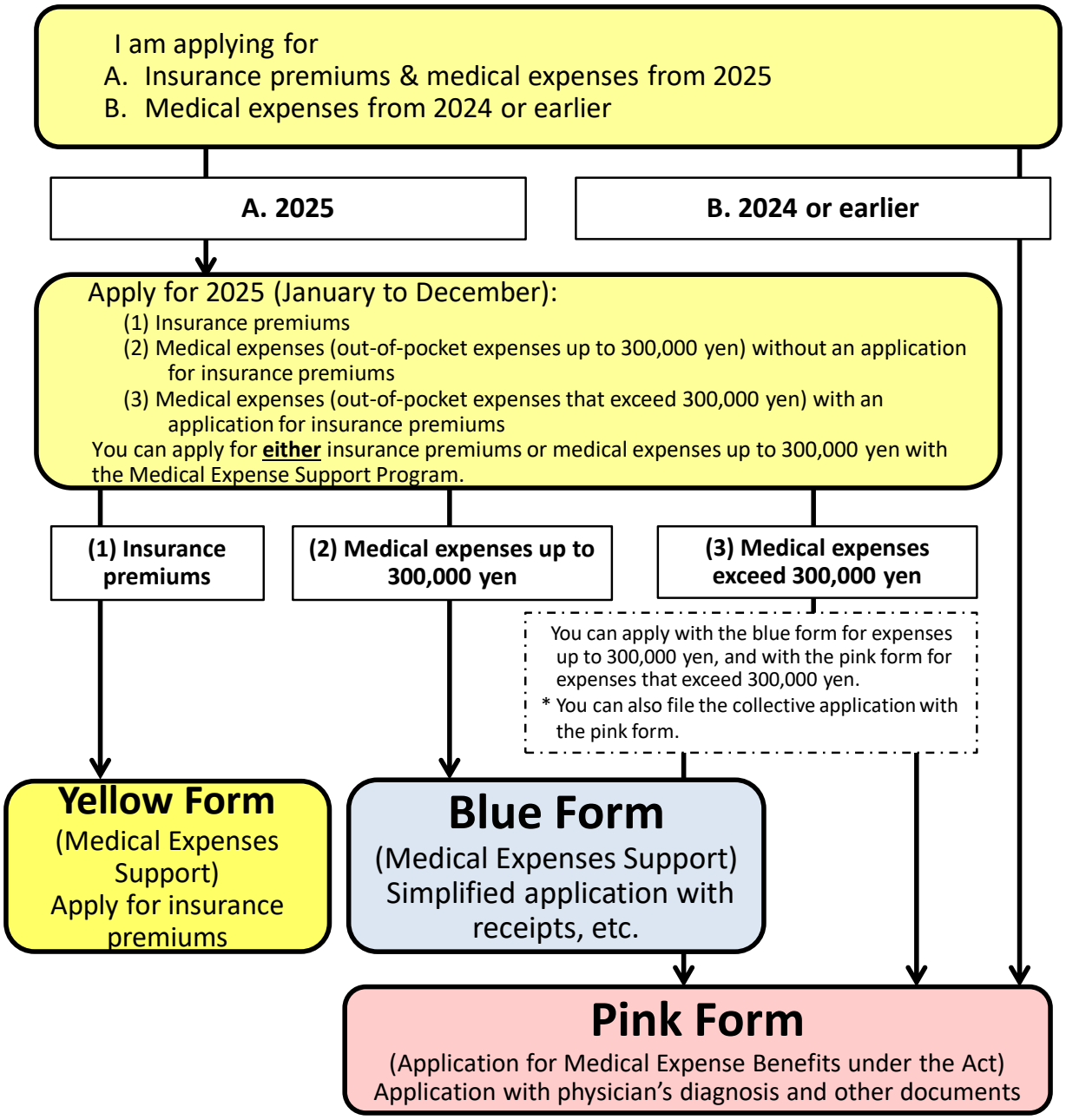
【Overview】

	1. Medical Expenses Support (Out-of-pocket expenses: 300,000 yen or less)	2. Medical Expense Benefits under the Act (Out-of-pocket expenses: exceed 300,000 yen)
Required documents	Simplified application procedure with receipts	Application procedure with physician's diagnosis and other documents
	○ Application form ○ Receipts (showing names of issuers, details, etc.) ○ Document showing your account for receiving benefits (VOID CHECK or copy of passbook) ○ Copy of your Atomic Bomb Survivor's Health Handbook	○ Application form ○ Receipts (showing names of issuers, details, etc.) ○ Document showing your account for receiving benefits (VOID CHECK or copy of passbook) ○ Copy of your Atomic Bomb Survivor's Health Handbook ○ Written diagnosis or other documents issued by medical institutions and drug stores stating details of the disease and its treatment
	Insurance premium: Refer to the yellow forms. **Medical expenses: Refer to the blue forms.**	Refer to the pink forms for details.
Submit to	Japan Public Health Association	
Deadline	Must reach by mid of January, 2026	–

Ceiling amount, etc.	Support is provided up to 300,000 yen/year.	The ceiling amount will be calculated based on examples of medical fees in Japan.
Remarks	Applicants can submit applications any number of times within the submission period.	Screening takes a lot of time. * It may take more than one year.

* Please ensure that the application date and signature are not omitted from the application form.

Selecting an Application



◎ 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 screening will take considerable time.

◎ Some treatments, such as those for beauty purposes, may not be covered by this system.

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

1. Application for Medical Expense Support

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

*1 The table below 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 2025, an application for Medical Expense Support can be filed within the scope provided under "Medical Expense Support ceiling" in the table.

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			
Country/region	Currency unit	Medical Expense Support ceiling	
Republic of Argentina	Argentine peso	2,000,000	ARS
Commonwealth of Australia	Australian dollar	3,126	AUD
Plurinational State of Bolivia	boliviano	12,971	BOB
Federative Republic of Brazil	real	10,601	BRL
Canada	Canadian dollar	2,838	CAD
People's Republic of China	renminbi	14,334	CNY
EU	euro	1,834	EUR
Republic of Indonesia	rupiah	29,411,765	IDR
United Mexican States	peso	36,015	MXN
Republic of the Philippines	Philippine peso	108,696	PHP
Republic of Singapore	Singapore dollar	2,669	SGD
Kingdom of Sweden	Swedish krona	19,557	SEK
Swiss Confederation	Swiss franc	1,760	CHF
Taiwan	new Taiwan dollar	64,795	TWD
Kingdom of Thailand	baht	66,667	THB
United Kingdom	UK pound	1,518	GBP
United States of America	US dollar	1,989	USD
Oriental Republic of Uruguay	Uruguayan peso	84,746	UYU
Socialist Republic of Vietnam	dong	48,387,097	VND

* Based on currency exchange rates at the beginning of April 2025

(1) Eligible persons

- Overseas atomic bomb survivors who have received an Atomic Bomb Survivor's Health Handbook or a Certificate of Confirmation of Atomic Bomb Exposure Status, and who wish to receive supports for medical expenses or insurance premiums incurred while receiving necessary medical treatment at a medical institution in their country of residence, provided that Hiroshima Prefecture or Nagasaki Prefecture has previously determined that it is appropriate to grant health care assistance.
- Surviving family members acting as a proxy for the above eligible person in the event that said eligible person is deceased

(2) Qualifying medical expenses

Benefits **of up to 300,000 yen per year (see *1 on page 4)** are available for the out-of-pocket expenses at an overseas medical institution.

- **Payments made in the one-year period** from January to December 2025
  - Insurance premiums and medical expenses paid based on a doctor's diagnosis, instructions, and prescriptions
  - Expenses for medical examinations
    The following expenses are not eligible for support in principle but may be eligible if accompanied by a doctor's instruction.
  - Over-the-counter drugs and drugs purchased based on self-decision
  - Yoga, Shiatsu, Acupuncture, Physical Therapy, Counseling, Massage, etc.

(3) Deadline

Please be aware that the application must reach no later than **mid of January, 2026**.

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

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

(4) Application procedures

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

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

(5) Application with combining Medical Expense Benefits under the Act

- If you have filed a Medical Expense Support application for insurance premium benefits and you pay for out-of-pocket medical expenses, you may apply for Medical Expense Benefits under the Act as described on page 8.
- If you have filed a Medical Expense Support application for medical expenses and you pay out-of-pocket medical expenses exceeding the annual provision ceiling amount of 300,000 yen (see*1 on page 4), under the Act you may apply for Medical Expense Benefits for this additional amount.

2. Application for Medical Expense Benefits under the Act

1. Under the Act, you may file an application for out-of-pocket medical expenses exceeding the annual provision ceiling for Medical Expense Support, which is 300,000 yen (see *1 on page 4) for medical expenses based on Atomic Bomb Survivors' Assistance Act.

(1) Eligible persons

- ○ Recipients of benefits for insurance premiums through the Medical Expense Support program
- ○ Persons with out-of-pocket expenses exceeding the annual provision ceiling for Medical Expense Support, which is 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) Expenses not recognized as relating to medical treatment under Japan's public health insurance
2) Advanced medical care and other treatment not covered by Japan's public health insurance
3) Treatment for which support is received under the Medical Expense Support program
4) Insurance premiums, etc.

Major Examples 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
- Nursing care facility expenses, nursing care expenses, and deposit on admission expenses for nursing care facility
- Admission expenses for nursing home

○ Medical treatment, assistive equipment and other fees not qualifying for benefits
- Implant treatment expenses
- Parking charges
- Expenses of transportation not involving medical treatment
- Drug or supplement expenses incurred without a prescription
- Expenses for medical exams that deviate from the purpose of treatment
- Vaccinations
- Advanced medical treatment
- Colostomy and urostomy bags
- Assist instruments, such as eyeglasses, hearing aids, walkers, and wheelchairs
- Beauty treatment, etc.

* For treatment using porcelain, zirconia, ceramics, or other materials not covered by Japan's public health insurance, you will only be covered up to the expenses for treatment using covered materials.

(3) Application procedures

Please refer to the pink form.

(4) Other information

○ An application for Medical Expense Benefits under the Act can be made even if the amount does not exceed the annual 300,000-yen ceiling.

○ If you apply for Medical Expense Benefits under the Act by submitting the required documentation for each of the time periods below, following a review, you may receive benefits (to cover your out-of-pocket expenses).
- 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

(For reference)

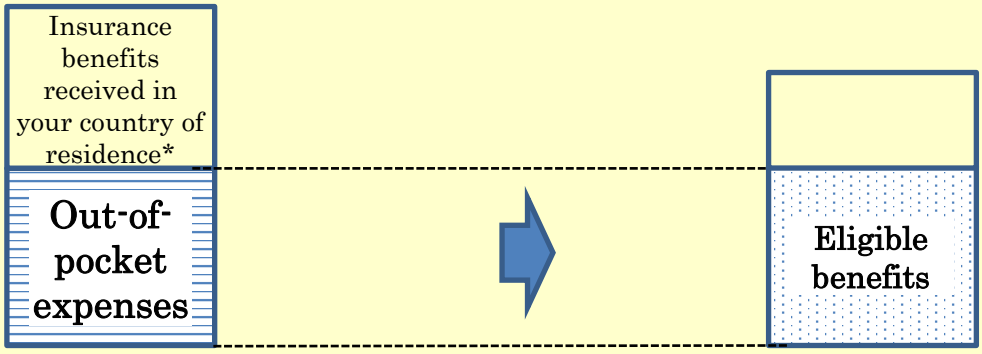
Calculation of Medical Expenses under the Act

(1) If the medical treatment received in your country of residence is comparable to treatment available in Japan, and the medical expenses converted to Japanese standard medical fees exceed your out-of-pocket expenses

⇒ **Your out-of-pocket expenses will be fully covered.**

* Since the medical expenses converted to Japanese standard medical fees exceed your out-of-pocket expenses, you will receive only the amount of the eligible benefits that is equal to the out-of-pocket expenses.

(Medical expenses incurred in your country of residence) (Converted to Japanese standard medical fees)

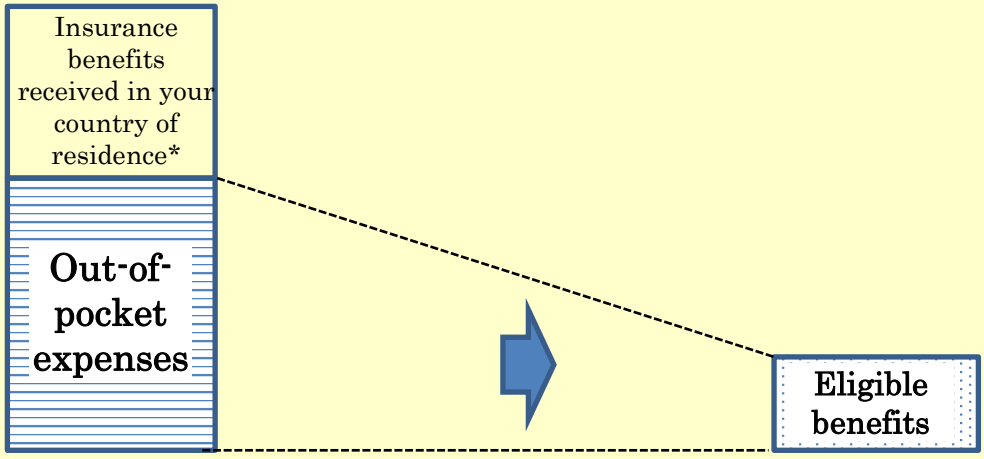


(2) If the cost of the medical treatment received in your country of residence is significantly higher than the cost of the same treatment in Japan

⇒ **Your out-of-pocket expenses will be partially covered.**

* If your out-of-pocket expenses exceed your eligible benefits, you will receive the full amount of the medical expenses converted to Japanese standard medical fees.

(Medical expenses incurred in your country of residence) (Converted to Japanese standard medical fees)



* Including public insurance benefits, private insurance benefits, and other benefits for the medical treatment

Medical Expense Support (Insurance Premiums) Application Procedure
For simplified application with a receipt, etc.

* Please make sure to submit documents 1 to 6 below.

Check	No.	Documents to Submit
□	1	Application Form for Medical Expense Support (Insurance Premiums) and Application Form for Confirmation of Eligibility (Form number 1)
□	2	Documents confirming the account to receive transfers (a copy of a passbook, check, etc.)
□	3	Medical Expense Support Benefit Breakdown In the case of monthly payment: Form number 1-2 In other cases: Form number 1-3
□	4	Insurance premium receipts that make it possible to confirm the following four pieces of information: 1) Amount paid 2) Name of the payer (same name as the applicant's) If the receipt contains insurance premium or the like for a person other than the applicant, only underline the portion that pertains to the applicant. 3) Name, address and phone number of insurance company. 4) Date of payment
□	5	A copy of the insurance policy * Medical insurance whose term of coverage includes the period from January to December 2025
□	6	A copy of one of the following: Atomic Bomb Survivor's Health Handbook; Notification of the Confirmation of Eligibility; Statements of Recognition for situation with regard to Atomic Bombing

Please submit the documents 7 and 8 as necessary. Only submit documents 9 through 12 if a surviving family member of a deceased atomic bomb survivor is applying for medical expense benefits.

□	7	Documents verifying identity * Please submit one of the following (issued within one month prior to application date) <u>if you are not receiving allowances (Healthcare Allowance, Health Allowance, Special Medical Care Allowance, or Special Allowance)</u>: ・A certified copy or extract of the family register, certificate by a notary public ・Residence permit, residence certificate, etc.
□	8	Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number) (Form number 2) * Please only submit this if there are changes to your home address, etc., when applying for insurance premiums.
□	9	Application Form for Medical Expense Support (Insurance Premiums) (For Application after Death) (Form number 3) * Submit 9 in place of 1. * Attach a document that makes it possible to confirm the date of death (a death certificate issued by a public institution or hospital).
□	10	Death Notification Form (Form number 4) * Submit this form only when applying for insurance premiums.
□	11	Documentation proving a family relationship or inheritance rights
□	12	Documents confirming the account to receive transfers (make sure that the account is in the name of the applicant who reports the death)

◆WHEN TO SUBMIT YOUR APPLICATION FORM

【Final deadline: Mid of January, 2026】

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

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

【Submit the Medical Expense Support (Insurance Premiums) application documents 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

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 3 to 8 (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.

If postal delivery is difficult, we will accept applications by email. Please send your application to the following address.

zaigai@jpha.or.jp

* Please be careful not to send them to the wrong address.

Form number 1

Application Form for Medical Expense Support (Insurance Premiums)
and Application Form for Confirmation of Eligibility

Notification number of the confirmation of eligibility for Medical Expense Support			—					
Atomic Bomb Survivor's Health Handbook No. (the number of the recipient of medical care covered by public expenses)								

Name		Date of birth (M/D/Y)		Sex:
Country of residence				
Address				
Telephone number				
E-mail				

Name of a contact person other than the applicant		Relationship with the applicant	
Telephone number *1			
E-mail *1			

Bank account for transfer *2	Name of financial institution	
	Branch name	
	Branch address	
	Account No.	
	Name of account holder	
	SWIFT/BIC Code	
	IBAN Code*3	
Amount of grants applied for	In local currency: (unit)	

*1 These information will be used only if it is unable to make contact to the applicant.

*2 ・Make sure to attach a photocopy of a bank book or papers which confirm the bank account.
・Bank accounts must be in the name of the applicant.

*3 The IBAN Code is required only for those residing in South America or Europe.

I hereby apply for Medical Expense Support for 2025 with the related documents attached.

Date: / / (M/D/Y)

Name of applicant:

*** 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

Medical Expense Support Benefit Breakdown (Payment by Monthly Installment)

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

Note 1: Please submit receipts, etc. for each month's expenses at the same time.

Note 2: Receipts must have the following 4 items:
(1) Amount paid to the insurance company
(2) Name of the payer (it should be identical to the name of applicant)
If the receipt includes insurance premiums, etc. for persons other than the applicant, please underline only the portion of applicant to specify the portion of the applicant.
(3) Name, location, and telephone number of the insurance company or hospital
(4) Date of the payment

Note 3: 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

Medical Expense Support Benefit 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: Receipts must have the following 4 items:

(1) Amount paid to the insurance company

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

If the receipt includes insurance premiums, etc. for persons other than the applicant, please underline only the portion of applicant to specify the portion of the applicant.

(3) Name, location, and telephone number of the insurance company or hospital

(4) Date of the payment

Note 3: 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 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:

_____

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

This form is only required when there are changes to be made at the time of applying for medical expenses.

Only fill out the items that have changed.

Notification number of the confirmation of eligibility for Medical Expense Support				–					
Name	Former name								
	New name								
Address	Former address								
	New address								
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 Health Handbook.

Form Number 3

Application Form for Medical Expense Support (Insurance Premiums) (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:		
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)		
E-mail			
Bank account for transfer *1	Name of financial institution		
	Branch name		
	Branch address		
	Account No.		
	Name of account holder		
	SWIFT/BIC Code		
	IBAN Code*2		
Amount of grants applied for	In local currency (unit)		

The applicant must attach papers certifying that they are the legal heir/heiress of the deceased and the certificate of death.

*1 ・Make sure to attach a photocopy of a bank book or papers which confirm the bank account.
・Bank accounts must be in the name of the applicant.
*2 The IBAN Code is required only for those residing in South America or Europe.

I hereby apply for Medical Expense Support for 2025 for the deceased person _____ 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

_____

*** 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									

* Please submit this form only when applying for insurance premiums.
* 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 Health Handbook.

Medical Expense Support (Medical) Application Procedure
For simplified application with a receipt, etc.

* Please make sure to submit documents 1 to 5 below.

Check	No.	Documents to Submit
□	1	Application Form for Medical Expense Support (Medical) and Application Form for Confirmation of Eligibility (Form number 5)
□	2	Documents confirming the account to receive transfers (a copy of a passbook, check, etc.)
□	3	Medical Expense Support Benefit Breakdown (Form number 5-2)
□	4	Receipts or other documents that make it possible to confirm the following four pieces of information: 1) Amount paid 2) 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. 3) Medical institution's name, address and phone number * Please send the following documents as necessary. • If drugs were purchased at a pharmacy with a doctor's prescription: the prescription or instruction • If proceeds were received from private insurance: certification of insurance proceeds, etc. 4) Date of payment
□	5	A copy of one of the following: Atomic Bomb Survivor's Health Handbook; Notification of the Confirmation of Eligibility; Statements of Recognition for situation with regard to Atomic Bombing

Please submit the documents 6 and 7 as necessary. Only submit documents 8 through 11 if a surviving family member of a deceased atomic bomb survivor is applying for medical expense benefits.

□	6	Documents verifying identity * Please submit one of the following (issued within one month prior to application date) <u>if you are not receiving allowances (Healthcare Allowance, Health Allowance, Special Medical Care Allowance, or Special Allowance)</u>: ・ A certified copy or extract of the family register, certificate by a notary public ・ Residence permit, residence certificate, etc.
□	7	Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number) (Form number 6) * Please only submit this if there are changes to your home address, etc., when applying for medical expenses.
□	8	Application Form for Medical Expense Support (Medical) (For Application after Death) (Form number 7) * Submit 8 in place of 1. * Attach a document that makes it possible to confirm the date of death (a death certificate issued by a public institution or hospital).
	9	Death Notification Form (Form number 8) * <u>Submit this form only when applying for medical expenses.</u>
□	10	Documentation proving a family relationship or inheritance rights
□	11	Documents confirming the account to receive transfers (make sure that the account is in the name of the applicant who reports the death)

◆ WHEN TO SUBMIT YOUR APPLICATION FORM

【Final deadline: Mid of January, 2026】

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

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

【Submit the Medical Expense Support (Medical Expenses) application documents 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

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 3 to 7 (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.

If postal delivery is difficult, we will accept applications by email. Please send your application to the following address.

zaigai@jpha.or.jp

* Please be careful not to send them to the wrong address.

Form number 5

Application Form for Medical Expense Support (Medical) and Application Form for Confirmation of Eligibility

Notification number of the confirmation of eligibility for Medical Expense Support				—					
Atomic Bomb Survivor's Health Handbook No. (the number of the recipient of medical care covered by public expenses)									

Name		Date of birth (M/D/Y)		Sex:
Country of residence				
Address				
Telephone number				
E-mail				

Name of a contact person other than the applicant		Relationship with the applicant	
Telephone number *1			
E-mail*1			

Bank account for transfer *2	Name of financial institution	
	Branch name	
	Branch address	
	Account No.	
	Name of account holder	
	SWIFT/BIC Code	
	IBAN Code*3	
Amount of grants applied for	In local currency: (unit)	

*1 These information will be used only if it is unable to make contact to the applicant.

*2 ・Make sure to attach a photocopy of a bank book or papers which confirm the bank account.
・Bank accounts must be in the name of the applicant.

*3 The IBAN Code is required only for those residing in South America or Europe.

I hereby apply for Medical Expense Support for 2025 with the related documents attached.

Date: / / (M/D/Y)

Name of applicant:

_____

*** 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 5-2

Medical Expense Support Benefit 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: Please submit receipts, etc. for each month's expenses at the same time.
Note 2: Receipts must have the following 4 items:
(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 3: Write amounts in the monetary unit of the country of residence.

Form Number 6

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:

_____

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

This form is only required when there are changes to be made at the time of applying for medical expenses.

Only fill out the items that have changed.

Notification number of the confirmation of eligibility for Medical Expense Support				–					
Name	Former name								
	New name								
Address	Former address								
	New address								
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 7

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:
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)		
E-mail			
Bank account for transfer *1	Name of financial institution		
	Branch name		
	Branch address		
	Account No.		
	Name of account holder		
	SWIFT/BIC Code		
	IBAN Code*2		
Amount of grants applied for	In local currency (unit)		

The applicant must attach papers certifying that they are the legal heir/heiress of the deceased and the certificate of death.

*1 ・Make sure to attach a photocopy of a bank book or papers which confirm the bank account.
・Bank accounts must be in the name of the applicant.

*2 The IBAN Code is required only for those residing in South America or Europe.

I hereby apply for Medical Expense Support for 2025 for the deceased person _____ 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

_____

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

Governor of Hiroshima Prefecture

Form Number 8

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									

* Submit this form only when applying for medical expenses.
* 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.
* Submit this form only when applying after death.

Procedure for Medical Expense Benefits Application Under the Act
Application if the amount exceeds 300,000 yen, etc.

* Please make sure to submit documents 1 to 5 below.

Check	No.	Documents to Submit
□	1	Application Form for Medical Expense and General Disease Medical Expense Payment and Application Form for Confirmation of Eligibility (Form number 9)
□	2	Documents confirming the account to receive transfers (a copy of a passbook, check, etc.)
□	3	Receipts or other documents that make it possible to confirm the following four pieces of information: 1) Amount paid 2) 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. 3) Medical institution's name, address and phone number * Please send the following documents as necessary. • If drugs were purchased at a pharmacy with a doctor's prescription: the prescription or instruction • If proceeds were received from private insurance: certification of insurance proceeds, etc. 4) Date of payment
□	4	Written diagnosis and observations by a physician indicating disease name, nature of treatment, etc.
□	5	A copy of the Atomic Bomb Survivor's Health Handbook

Please submit documents 6 to 8 as necessary. Only submit documents 8 through 11 if a surviving family member of a deceased atomic bomb survivor is applying for medical expense benefits.

□	6	Copy of certification of the Authorization of Atomic Bomb Disease * Only submit this if receiving a special medical allowance.
□	7	Documents verifying identity * Please submit one of the following (issued within one month prior to application date) <u>if you are not receiving allowances (Healthcare Allowance, Health Allowance, Special Medical Care Allowance, or Special Allowance)</u>: ・A certified copy or extract of the family register, certificate by a notary public ・Residence permit, residence certificate, etc.
□	8	Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number) (Form number 10) * Please only submit this if there are changes to your home address, etc., when applying for medical expenses.
□	9	Application Form for Medical Expense and General Disease Medical Expense Payment (For Application after Death) (Form number 11) * Submit 9 in place of 1. * Attach a document that makes it possible to confirm the date of death (a <u>death certificate issued by a public institution or hospital</u>).
□	10	Death Notification Form (Form number 12) * Submit this form only when applying for medical expenses.
□	11	Documentation proving a family relationship or inheritance rights
□	12	Documents confirming the account to receive transfers (make sure that the account is in the name of the applicant who reports the death)

◆ WHEN TO SUBMIT YOUR APPLICATION FORM

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

However, the review requires considerable time to calculate the cost of similar treatment if provided in Japan. Therefore, please be aware that it takes a while for applicants to receive benefits.

【Submit the Medical Expense Benefits under the Act application documents 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

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 3 to 6 (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.

If postal delivery is difficult, we will accept applications by email. Please send your application to the following address.

zaigai@jpha.or.jp

* Please be careful not to send them to the wrong address.

Form number 9

Application Form for Medical Expense and General Disease Medical Expense Payment and Application Form for Confirmation of Eligibility

Notification number of the confirmation of eligibility for Medical Expense Support			—					
Atomic Bomb Survivor's Health Handbook No. (the number of the recipient of medical care covered by public expenses)								

Name		Date of birth (M/D/Y)		Sex:
Country of residence				
Address				
Telephone number				
E-mail				

Name of a contact person other than the applicant		Relationship with the applicant	
Telephone number *1			
E-mail*1			

Bank account for transfer *2	Name of financial institution	
	Branch name	
	Branch address	
	Account No.	
	Name of account holder	
	SWIFT/BIC Code	
	IBAN Code*3	
Certified or not certified as an atomic bomb disease at the application		Certified / Not certified
Amount of grants applied for	In local currency:	(unit)

*1 These information will be used only if it is unable to make contact to the applicant.

*2 ・Make sure to attach a photocopy of a bank book or papers which confirm the bank account.
・Bank accounts must be in the name of the applicant.

*3 The IBAN Code is required only for those residing in South America or Europe.

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:_____

*** 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 10

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: _____

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

This form is only required when there are changes to be made at the time of applying for medical expenses.

Only fill out the items that have changed.

Notification number of the confirmation of eligibility for Medical Expense Support				–					
Name	Former name								
	New name								
Address	Former address								
	New address								
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 (General Disease Medical Expense) Support. There are separate procedures for the local administration that issued the Atomic Bomb Survivor's Handbook.

Form Number 11

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:
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)		
E-mail			
Bank account for transfer*1	Name of financial institution		
	Branch name		
	Branch address		
	Account No.		
	Name of account holder		
	SWIFT/BIC Code		
	IBAN Code*2		
Amount of grants applied for	In local currency (unit)		

The applicant must attach papers certifying that they are the legal heir/heiress of the deceased and the certificate of death.

*1 ・Make sure to attach a photocopy of a bank book or papers which confirm the bank account.
・Bank accounts must be in the name of the applicant.

*2 The IBAN Code is required only for those residing in South America or Europe.

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_____

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

Governor of Hiroshima Prefecture

Form Number 12

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								

* This notification is for filing an application for the Medical Expense (General Disease Medical Expense) Support. There are separate procedures for the local administration that issued the Atomic Bomb Survivor's Handbook.

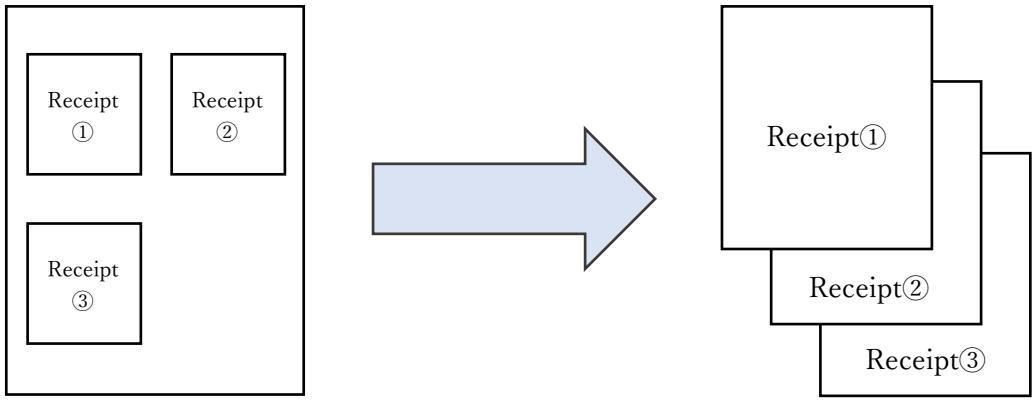
* Submit this form only when applying after death.

【Important】Submission of receipts

1. Change in receipt submission procedure <common>

【Change detail】

Previously, in order to prevent the loss of receipts, we requested that receipts be affixed to monthly receipt sheets. However, from 2025, such sheets are abolished. From now on, please submit receipts **as they are, without affixing them to the receipt sheets**.



【Submission procedures】

- ✧ **Please submit the receipts as they are.**
- ✧ Do not glue or staple them.
- ✧ If you need to hold them together, use a clip or removable tape.
- ✧ Receipts must include the following four items.
  - ① Paid amount
  - ② Name of the person who received medical care (or name of the person who paid the insurance premium)
    * If the expenses of other persons are included, please underline and indicate the portion attributable to the applicant.
  - ③ Name, location and telephone number of the medical institution (or insurance company)
  - ④ Payment date

2. Submission of thermal paper receipts <common>

- ✧ Thermal paper tends to fade characters over time, so please submit copies or scans.
- ✧ If copying is difficult, submission of PDF files via email is acceptable.
- ✧ Please note that if the characters are illegible, application itself may be invalid.

3. Notes regarding receipts <Application for Medical Expense Benefits under the Act>

- ✧ Receipts that only show the amount cannot be used to accurately calculate the amount to be supported.
- ✧ Please be sure to submit one of the following.
  - ・Receipts clearly stating medical procedures and examination details
  - ・Or, a separate sheet (statement) detailing the medical treatment provided

* Submission of examination results is not required. Please provide details of "what medical treatment or examinations are provided." If the description is unclear, the amount to be supported may not be calculated.

We appreciate your understanding and cooperation in ensuring that the application process proceeds smoothly.

For the application under the Act, please note the followings.

◎Example of a receipt containing the necessary information◎

Receipt ①ABC Hospital

②John Smith

③2025/5/27 Examination fee ④40 USD

2025/6/08 Examination fee CT Blood test 155USD

△Example of an incomplete receipt△

Invoice ①ABC Hospital ③2025/1/23

As the treatment fee ④155USD (invoiced amount)

We cannot calculate the amount to be supported based on the document without names and details, which makes it unclear what medical service was provided.

First, please fill in your name by hand.

Then, fill in the blank space with the details of the medical treatment.

In case of the invoice, please additionally attach a certificate for payment.

Invoice ①ABC Hospital ③2025/1/23

As the treatment fee ④155 USD

② John Smith Examination CT Blood test

+ *Certificate for payment, etc.*

Description of “Amount Due” or “You Pay” does not certify your payment. When submitting an invoice, please be sure to attach a receipt (such as a credit card statement or a copy of a check) that matches the amount. Please submit receipts described such as “Amount Due: 0.00” or “You Paid.”