

# Notification of Change of Covered Dependents (Addition)

常務理事	事務長		担当

Insurance card code and number	Name of the insured person	Furigana			Date of birth			Gender	Date of acquisition of eligibility		
		(Y)	(M)	(D)	Male	(Y)	(M)	(D)			
Address of the insured person	Telephone	( )						Standard monthly remuneration	.000 yen (in thousands of yen)		
									( )	( )	( )

Type of change	Name of dependent	Date of birth	Gender	Relationship	Occupation or year in school	Annual expected income (including tax)	Household	Day on which support began	Individual Number	
									Reason/Remarks	
Addition	Furigana (Last name)	(Y) (M) (D)	M			yen	Living together	(Y) (M) (D)		
	(First name)		F				Living separately			
Addition	Furigana (Last name)	(Y) (M) (D)	M			yen	Living together	(Y) (M) (D)		
	(First name)		F				Living separately			
Addition	Furigana (Last name)	(Y) (M) (D)	M			yen	Living together	(Y) (M) (D)		
	(First name)		F				Living separately			
Addition	Furigana (Last name)	(Y) (M) (D)	M			yen	Living together	(Y) (M) (D)		
	(First name)		F				Living separately			
Addition	Furigana (Last name)	(Y) (M) (D)	M			yen	Living together	(Y) (M) (D)		
	(First name)		F				Living separately			

事業主の 確認	事業所所在地
	事業所名称
	事業主氏名
	電話

Date of submission (Y) (M) (D)

社会保険労務士の提出代行記載欄

受付日付印

To the HGST Health Insurance Association