

Notification of Change of Covered Dependents (Removal) *Please attach the insurance card.

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	Relation ship	Occupation or year in school	Annual expected income (including tax)	Household	Date individual was no longer a dependent			Reason	Remarks
Reduction	Furigana		(Y)	(M)	(D)	M		yen	Living together Living separately	(Y)	(M)	(D)			
	(Last name)	(First name)				F									
Reduction	Furigana		(Y)	(M)	(D)	M		yen	Living together Living separately	(Y)	(M)	(D)			
	(Last name)	(First name)				F									
Reduction	Furigana		(Y)	(M)	(D)	M		yen	Living together Living separately	(Y)	(M)	(D)			
	(Last name)	(First name)				F									
Reduction	Furigana		(Y)	(M)	(D)	M		yen	Living together Living separately	(Y)	(M)	(D)			
	(Last name)	(First name)				F									
Reduction	Furigana		(Y)	(M)	(D)	M		yen	Living together Living separately	(Y)	(M)	(D)			
	(Last name)	(First name)				F									

事業主の確認	事業所所在地
	事業所名称
	事業主氏名
	電話

◎ To remove a dependent due to the start of employment insurance, please attach a copy of the employment insurance benefit qualification certificate which lists the start date for receiving employment insurance.

社会保険労務士の提出代行記載欄

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

受付日付印

*Please indicate if you would like issuance of losing qualification in the Remarks section.