

武田薬品健康保険組合理事長殿

To: Chairman of the Board, Takeda Health Insurance Society

念 書

Written Pledge (In connection with injury or sickness due to a third-party act)

平成 年 月 日 事故発生場所[]
において加害者[]の不正行為により被害者[]の被った保険事故について健康保険法による保険給付を受けた場合は、私に加害者に対して有する損害賠償請求権を健康保険法第57条の規定によって健康保険組合が給付金額の限度において取得行使し、かつ賠償金を受領することに異議のないことをここに書面をもって申しのべます。

なお、あわせて次の事項を遵守することを誓約します。

I hereby acknowledge in writing that I do not object to the Health Insurance Society exercising my right to submit a claim for damages and to seek compensation for damages from the party responsible, up to the amount of benefits under Article 57 of the Health Insurance Act, in the event that I used health insurance for the treatment of injuries under the Health Insurance Act following the accident that occurred on the victim [name: _____] due to the improper actions of the party responsible [name: _____] at the scene of the accident [Location: _____] on the date ____ (Y)/ ____ (M)/ ____ (D).

I also pledge to comply with the following terms:

1. 加害者と示談を行おうとする場合は必ず前もって貴職にその内容を申し出ます。
 2. 加害者に白紙委任状を渡しません。
 3. 加害者から金品を受領したときは、受領年月日、内容、金額（評価額）をもれなくかつ遅滞なく貴職に届け出ます。
 4. 自賠責保険に被害者請求をする場合は、必ず前もって貴職にその内容を届け出ます。また被害者に関して、事故発生状況・治療状況など、求償に必要と認められる事項について、損害保険会社、医療機関に照会されること及び求償に際して、損害保険会社へ被害者のレセプト（写）を添付することを承諾します。
1. I agree to notify you in advance of all details before settling with the party responsible.
 2. I agree not to give the party responsible blank power of attorney.
 3. I agree to notify you promptly and without omission of the date of receipt, details, and amount (assessed value) of any money or goods received from the party responsible.
 4. I agree to notify you in advance of all details before making any claims as a victim under automotive liability insurance. I also consent to the attachment of the victim's Rezepts (medical cost details) (copies) to documents submitted to the casualty insurance company when filing claims for damages and to inquiries submitted to the casualty insurer and medical care institutions with regard to matters deemed necessary concerning the victim, including the conditions under which the accident occurred and the status of treatment.

年 月 日

Date (Y/M/D): / /

被保険者氏名/Name of insured person: _____ (seal)	
事故当事者名/Name of person involved in accident: _____	
(続柄/Relationship: _____)	
事業所/所属: Employer/Section:	社内 TEL/Ext. tel.
被保険者住所/Address of insured person: 〒	
TEL ()	