

年 月 日
Date(Y/M/D): / /

武田薬品健康保険組合理事長 殿
To: Chairman of the Board, Takeda Health Insurance Society

事業所/Employer _____

被保険者記号・番号/Insured person code and no.

被保険者氏名/Name of insured person

第三者行為保険事故による保険給付返還免除申請書
Application Form for Exemption from Refunding of Health Insurance Benefits
(In connection with injury or sickness due to a third-party act)

年 月 日発生（第三者行為による傷病届第 号）の第三者行為による保険事故に関し、健康保険組合が行った保険給付について、返還の免除を申請いたします。

I hereby request an exemption from the requirement to refund the insurance benefits paid by the Health Insurance Society in connection with the accident due to the actions of a third party that occurred on (Y)/ (M)/ (D) (as described in Notification of Injury or Sickness due to a Third-party Act No.).

[免除申請理由/Reason for application for exemption]

1. 第三者からの損害賠償額が健康保険組合の行った保険給付額に達しない。
The amount of damages paid by the third party was less than the amount of insurance benefits paid by the Health Insurance Society.

2. その他
Other

[]

受付年月日	平成 年 月 日				
常務理事 Managing Director	事務長 Office Manager	課長・L Leader	担当者 In charge	保険給付額	円 yen
				返済額	円 yen
				返還免除額	円 yen