Health Insurance Association for Amazon Japan Employees

被扶養者異動届（扶養削除）

Notification of Health Insurance Dependent Change (Dependent Deletion)

常務理事	事務長	担当者

Attached document #1 Please send the dependent's (family) insurance card to be deleted to the SATO Social Insurance and Labor Professional Corporation.

Attached document #2 If you want to delete the employment insurance due to the start of receiving the employment insurance, please attach a copy of the qualification card with the start date.

Submitted Year Month Day

◎ Fill in the information of the applicant (employee) 【 Fill or check the yellow cells Fill in green cells as needed 】

Insurance Card	Code		Number		Employee ID Number	

The insured person

Name	katakana	Date of Birth
	Name of Insured	Year Month Day
Address	〒 — Phone ( )	

Insured person confirmation (Always check)	☐ * Completed by the insured person (applicant) and the content is correct (Omitted name stamp) ☐ * I would like to issue a certificate of disqualification
Delivery address (No need if same as above)	〒 —

◎ Enter the information of the dependent (family) to be deleted. ＊Children fill in like eldest son, second daughter.

Dependent

Name	katakana	relationship	☐ male ☐ female	Date of Birth
	Name			Year Month Day

Reasons for deleting dependents (Date that occurred reasons)	Date to remove dependents
☐ Dependent employment (Hire date) ☐ Increasing income (Submission date) ☐ Divorced (Date of devorce) ☐ Mortality (The day after the day of death) ☐ Other reason ( )	Year Month Day

Dependent

Name	katakana	relationship	☐ male ☐ femal	Date of Birth
	Name			Year Month Day

Reasons for deleting dependents (Date that occurred reasons)	Date to remove
☐ Dependent employment (Hire date) ☐ Increasing income (Submission date) ☐ Divorced (Date of devorce) ☐ Mortality (The day after the day of death) ☐ Other reason ( )	Year Month Day

Dependent

Name	katakana	relationship	☐ male ☐ femal	Date of Birth
	Name			Year Month Day

Reasons for deleting dependents (Date that occurred reasons)	Date to remove
☐ Dependent employment (Hire date) ☐ Increasing income (Submission date) ☐ Divorced (Date of devorce) ☐ Mortality (The day after the day of death) ☐ Other reason ( )	Year Month Day

事業主欄	☐ 被保険者に届出の意思を確認しました。

事業主

所在地

名称

事業主名

電話番号

社会保険労務士

受付