Comprehensive Insurance for Student Lives Coupled with "Gakkensai" for International Students/Incident Report Form

Please fill in the form using Japanese if you are able to do so.

1. Please provide the details on the policyholder

(1) Policyholder Number

(2) Date of Birth

(3) Name (spelling) (Kana)

(4) Name of University

(5) Student Number

(6) E-mail Address @

(7) Telephone Number (In Japanese ☐ Yes ☐ No)

(8) Document Mailing Address Zip Code 〒

2. Please provide the details on the claim

<When Claiming Medical Expenses>

The following cases are NOT covered.
Please proceed after making verification.

Expenses NOT covered by health insurance ·Dentist visit for dental disease
·Congenital disease ·Mental disorder
·Pregnancy, Birth (covered when health insurance is applicable)
·Hemorrhoid, anal fissure, anal fistula
·Continuing treatment for injury or illness acquired before signing is NOT covered for 2 years from the date of signing
·Treatment expenses beyond the valid period*

I have made verification. The injury or illness is NOT ineligible.

- If you have received treatment for illness
- If you have received treatment for injury

*The valid period shall continue until the last day of the month in which the 60th day following the first medical examination falls.
In regard to the same injury or illness, this coverage is valid in the case that 180 days have passed from the last day

〈When Claiming Liability Insurance〉

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<For Illness Claims>

(1) Provide us with the name listed on the health insurance card	
(2) Provide us with the name of the illness	
(3) Provide us with the date you first visited the hospital The valid period shall continue until the last day of the month in which the 60th day following the first medical examination falls.	Year Month Day ☐ Treatment complete ☐ Currently under treatment
(4)Were you hospitalized?	☐ None ☐ Yes (From to)
Do you plan to be hospitalized in the future?	☐ None ☐ Yes (Around month later)
(5) For which body part did you receive treatment? **Ineligible** items ar as follows. ·Expenses NOT covered by health insurance ·Dentist visit for dental disease ·Congenital disease ·Mental disorder ·Pregnancy, Birth (covered when health insurance is applicable) ·Hemorrhoid, anal fissure, anal fistula ·Treatment expenses after the valid period ·Continuing treatment for injury or illness acquired before signing is NOT covered for 2 years from the date of signing	☐ Head ☐ Face ☐ Eye ☐ Nose ☐ Ear ☐ Tooth ☐ Neck ☐ Shoulder ☐ Chest ☐ Stomach ☐ Back ☐ Hip ☐ Arm(☐ Right ☐ Left) ☐ Foot(☐ Right ☐ Left) ☐ Finger (☐ Right ☐ Left) ☐ Toe (☐ Right ☐ Left) ☐ Other ( )
(6) What were the symptoms?	☐ Fever ☐ Cold ☐ Pain ☐ Other ( )

(Please answer the following questions)

(7) Was this the first time you were treated for this illness?	☐ Yes ☐ No (Please answer questions (9) and (10))
(8) What was the number of points in the field titled "初再診" on the receipt for your fist hospital visit?	☐ 282 or more ☐ Less than 282 points
(9) When did you begin receiving treatment?	From year month day
(10) Was there a period when you were fully recovered?	☐ Yes (From to)
* This includes periods during which treatment was suspended.	☐ No (receiving regular treatment)

Thank you for entering your information.

insclaim.futaigakuso@tmnf.jp

Please send this file to the e-mail address shown in the left after the completion of entering.
E-mail will open automatically after clicking the address.
<Note>
◎Please have the subject of the e-mail as "Insurance claim ●●●● (← your 14 digit subscriber number)".
*Please do not write anything in the email but send the attachment only.
*If the e-mail does not start up, please open an e-mail on your own, manually attach this file and send it to the e-mail address shown in the left.

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<For Injury Claims>

(1) Provide us with the name listed on the health insurance card	

(2) Provide us with the name of the injury or illness	
(3) What were you doing at the time of injury?	☐ During the regular curriculum/school event ☐ During travel to/from school ☐ During club activities ☐ Private (unrelated to school)
(4) What was the situation?	☐ Fall ☐ Collision ☐ Cut ☐ Crushed ☐ Other ( )
(5) Provide us with the date you first visited the hospital The valid period shall continue until the last day of the month in which the 60th day following the first medical examination falls.	Year Month Day ☐ Treatment complete(Until) ☐ Under treatment
(6) Were you hospitalized?	☐ None ☐ Yes (From to)
Do you plan to be hospitalized in the future?	☐ None ☐ Yes (Around month later)
(7) For which body part did you receive treatment? **Ineligible** items are as follows. ·Expenses NOT covered by health insurance ·Dentist visit for dental disease ·Congenital disease ·Mental disorder ·Pregnancy, Birth (covered when health insurance is applicable) ·Hemorrhoid, anal fissure, anal fistula ·Treatment expenses after the valid period ·Continuing treatment for injury or illness acquired before signing is NOT	☐ Head ☐ Face ☐ Eye ☐ Nose ☐ Ear ☐ Tooth ☐ Neck ☐ Shoulder ☐ Chest ☐ Stomach ☐ Back ☐ Hip ☐ Arm ☐ Foot ☐ Finger ☐ Toe ☐ Other ( )
Please tell us whether it was on the left or right side	☐ Left ☐ Right ☐ Unknown
(8) What were the symptoms?	☐ Cut ☐ Bruise ☐ Broken bone ☐ Dislocation ☐ Sprain ☐ Burn ☐ Other ( )

(Please answer the following questions)

(9) Was this the first time you were treated for your injury?	☐ Yes ☐ No (Please answer questions (7) and (8))
(10) What was the number of points in the field titled "初再診" on the receipt for your fist hospital visit?	☐ 282 or more ☐ Less than 282 points
(11) When did you begin receiving treatment?	From year month day
(12) Was there a period when you were fully recovered?	☐ Yes (From to)
* This includes periods during which treatment was suspended.	☐ No (receiving regular treatment)

Thank you for entering your information.

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<For Personal Liability Insurance>

(1) Date/Time of occurrence	Year Month Day Approximate time :
(2) Contact for the other party	Name Phone Address
(3) Future contact	☐ Above(2) ☐ Other(Name Relationship Phone) ☐ Insurance Company (Company Name) Representative Phone)
(4) Type of accident	☐ Water leaks going to lower floors ☐ Property damage to other person's property ☐ Other ( )

☐ Traffic accident (please check the following)

Bicycle ☐ Pedestrian Automobiles and motorcycles are NOT covered

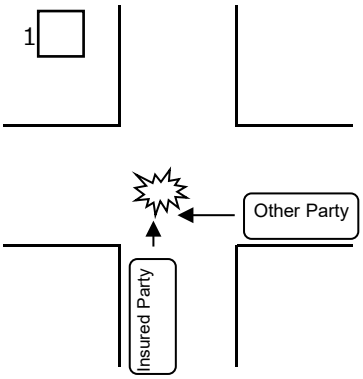
Was the insured party injured? ☐ Yes ☐ No

What was the other party's vehicle? ☐ Automobile ☐ Motorcycl ☐ Bicycle ☐ Pedestrian ☐ Non-persons (fence, etc.)

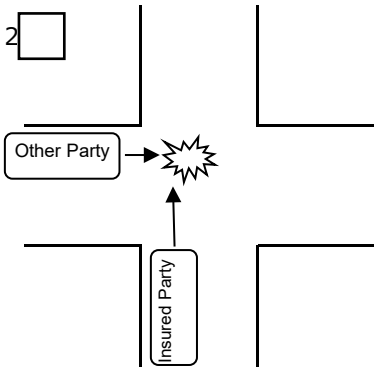
Was the other party injured? ☐ Yes ☐ No

Please select the most similar type of accident.

1 ☐



2 ☐



3 ☐ Other A person who can describe the situation should do so below

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