

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

Zip Code 〒

Address

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 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 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 first 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
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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? Do you plan to be hospitalized in the future?	☐ None ☐ Yes (From to) ☐ 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)		

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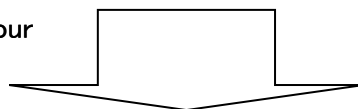
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<For Personal Liability Insurance>

(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 Motorcycle 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 Party → Insured Party ↑ Other Party ← Insured Party ↑ Other Party → Insured Party ↑ Other A person who can describe the situation should do so below

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