

No.

国民健康保険特定疾病認定申請書						
被保険者証の 記号番号	記号	市	番号		種別	一般・退職
認定を受けようとする被保険者の氏名及び生年月日	氏名				性別	男・女
	個人番号					
	生年月日		昭・平・令 年 月 日			
特定疾病の名称 該当する番号に○印を付けてください。	1 人工腎臓を実施している慢性腎不全。 2 血漿分画製剤を投与している先天性血液凝固第Ⅷ因子障害または先天性血液凝固第Ⅸ因子障害。 3 抗ウイルス剤を投与している後天性免疫不全症候群。 (HIV感染を含み、厚生労働大臣の定める者に係るものに限る)					
国民健康保険特定疾病認定書を上記のとおり申請します。						
年 月 日 世帯主 住所 市川市 丁目 番号 () 氏名 個人番号 市川市長 あて 電話 ()						
証 明 書						
上記 _____ は <div>1 人工腎臓を実施している慢性腎不全。 2 血漿分画製剤を投与している先天性血液凝固第Ⅷ因子障害または先天性血液凝固第Ⅸ因子障害。 3 抗ウイルス剤を投与している後天性免疫不全症候群。 (HIV感染を含み、厚生労働大臣の定める者に係るものに限る)</div> で 治療していることを証明します。						
年 月 日 医療機関の 所在地 名称 医師名 印						

Ichikawa — 国民健康保険異動届出書 — National Health Insurance Application

Deadline: Must be submitted within 14 days of the qualifying event (losing employer insurance, moving in, birth, etc.) | Cost: Free | Penalty: Late enrollment means you still owe premiums from the eligibility date, and medical costs in

WHAT TO BRING

>> Enrolling after leaving employer insurance

- | | |
|---|-------------|
| * Certificate of Health Insurance Loss (from former employer) | 健康保険資格喪失証明書 |
| * Residence Card | 在留カード |
| * My Number Card (or My Number notification) | マイナンバーカード |
| Bank passbook & registered seal (for auto-debit setup) | 通帳・届出印 |

>> Enrolling after moving to a new ward

- | | |
|--|-----------|
| * Residence Card | 在留カード |
| * My Number Card | マイナンバーカード |
| Moving-Out Certificate (from previous ward) (If also doing residence registration) | 転出証明書 |

>> Leaving NHI (got employer insurance)

- | | |
|---|-------------|
| * New health insurance card (from employer) | 新しい健康保険証 |
| * NHI qualification confirmation document | 国民健康保険資格確認書 |
| * My Number Card | マイナンバーカード |

COMMON MISTAKES

- X Not enrolling within 14 days
 - > You owe premiums retroactively from the eligibility date, but medical expenses during the gap are not covered.
- X Forgetting to disenroll from NHI after getting employer insurance
 - > You will be double-billed for premiums. NHI does not automatically cancel.
- X Not bringing the Certificate of Health Insurance Loss
 - > The ward office cannot process your enrollment. Ask your former employer to issue this document.

AFTER YOU SUBMIT

1. You receive a qualification confirmation document (資格確認書) — keep this as proof of insurance
2. Monthly premium notices arrive by mail. Pay at convenience stores, banks, or set up auto-debit
3. Dependents can be enrolled on the same form — list all household members
4. Premiums are calculated based on your previous year's income

セクション 1 — Section 1

No.

国民健康保険特定疾病認定申請書				
被保険者証の 記号番号	記号	市	番号	種別 一般・退職
認定を受けようとする 被保険者の氏名	氏名			性別 男・女

- 1 国民健康保険特定疾病認定申請書 National Health Insurance
Japan's public health insurance for self-employed, unemployed, and those not covered by employer insurance. Enrollment is mandatory.
- 2 被保険者証の記 Insurance card / Insured person
Refers to your national health insurance card - this field likely continues with additional text The person covered by the insurance policy (usually yourself when applying)
- 3 一般・退職 General/Retirement
Select "General" for standard health insurance or "Retirement" if you're enrolled in a retiree health insurance plan
- 4 号号 No. No.
N/A - this appears to be column headers or form layout text for numbering fields
- 5 男・女 Male · Female
Circle or check the appropriate gender option
- 6 認定を受けようとする Seeking to receive certification/approval
This appears to be incomplete text - likely part of a longer phrase about applying for official recognition or certification status.
- 7 る被保険者の氏名及 Full name
Write in katakana for foreign names. Some forms accept romaji.



セクション 2 — Section 2 (Part 1/2) (continued)

1 認定を受けようとする る被保険者の氏名及び 生年月日		2 個人番号											別	
		4 生年月日	昭・平・令 年 月 日											
6 特定疾病の名称		5 1 人工腎臓を実施している慢性腎不全。 7 2 血漿分画製剤を投与している先天性血液凝固第Ⅷ因子障害または 8 先天性血液凝固第Ⅸ因子障害。 9 10 3 抗ウイルス剤を投与している後天性免疫不全症候群。 11 (HIV 感染を含み、厚生労働大臣の定める者に係るものに限る) 12												
13 該当する番号に○印 を付けてください。														
14 国民健康保険特定疾病認定書を上記のとおり申請します。														
15 年 月 日														
世帯主 住所 市川市 丁目 番 号														

- 12 (HIV感染を含み、厚生労働大臣の定める者に係るものに限る)
(Including HIV infection, limited to cases pertaining to persons designated by the Minister of Health, Labour and Welfare)
This is a clarification note for condition 3 above - it specifies that acquired immunodeficiency syndrome includes HIV infection, but only applies to cases involving persons designated by the Minister of Health, Labour and Welfare. No action is required for this explanatory text.
- 13 国民健康保険特定疾病認定書を上記のとおり申請します。 National Health Insurance / . / Document
Japan's public health insurance for self-employed, unemployed, and those not covered by employer insurance. Enrollment is mandatory.
- 14 年 月 日 Year Month Day
Write the date in Japanese format (year/month/day) using Arabic numerals, e.g., 2024年12月15日
- 15 世帯主 住所 市川市 Head of household / Address
The primary person in a household for registration purposes. If you live alone, you are the head of household. Write in kanji if possible. Ward office staff can help you look up the correct kanji for your address.

セクション 2 — Section 2 (Part 2/2)

	世帯主住所市川市	丁目	番	号
--	----------	----	---	---

1

丁目

Block number

Part of Japanese address system - the district block number (e.g., 1-chome, 2-chome)



セクション 3 — Section 3

1

() ()

2

氏 名

3

個人番号

4

電 話

()

5

市川市長 あて

6

1 人工腎臓を実施している慢性腎不全。

7

2 血漿分画製剤を投与している先天性血液凝固第Ⅷ因子障害または先天性血液凝固第Ⅸ因子障害。

8

3 抗ウイルス剤を投与している後天性免疫不全症候群。

9

(HIV 感染を含み、厚生労働大臣の定める者に係るものに限る)

10

上記 _____ は _____ で

11

治療していることを証明します。

- 1

() ()

Write your full name in katakana as it appears on your residence card or official documents.
- 2

氏名 Full name

Write in katakana for foreign names. Some forms accept romaji.
- 3

個人番号 My Number (Individual Number)

12-digit number. Leave blank on first registration — it will be mailed to you after.
- 4

電話 Phone number

Japanese mobile number preferred. Some forms accept overseas numbers.
- 5

市川市長 あて To the Mayor of Ichikawa City

This field is pre-filled and indicates the form is addressed to the Mayor of Ichikawa City - no action needed.
- 6

1 人工腎臓を実施している慢性腎不全。 Chronic renal failure undergoing artificial kidney treatment

Check if you have chronic kidney failure and are receiving dialysis treatment
- 7

2 血漿分画製剤を投与している先天性血液凝固第Ⅷ因子

2. Congenital blood coagulation factor VIII with plasma fractionation product administration

Check this box if you have congenital hemophilia A and receive factor VIII concentrate treatments
- 8

上記 は The above is/are

This is layout text that precedes a statement about the people listed above - you don't fill this in directly, but complete the statement that follows.
- 9

障害または先天性血液凝固第Ⅸ因子障害。 Disability or congenital blood coagulation factor IX disorder.

Check this box only if you have hemophilia B or other factor IX clotting disorders - leave blank for most residents.
- 10

3 抗ウイルス剤を投与している後天性免疫不全症候群。 3. Acquired immunodeficiency syndrome being treated with antiviral drugs.

Check this box if you have AIDS and are currently receiving antiviral medication treatment.
- 11

(HIV感染を含み、厚生労働大臣の定める者に係るものに限る)

(Including HIV infection, limited to cases pertaining to persons designated by the Minister of Health, Labour and Welfare)

This is explanatory text about HIV infection and conditions designated by the Minister of Health, Labour and Welfare - no input required from you.



<div style="position: relative; height: 100px;"> () </div>	<div style="text-align: center;"> <div style="position: relative; height: 100px;"> () </div> </div>
<div style="position: relative; height: 100px;"> 市川市長 あて </div>	<div style="text-align: center;"> <div style="position: relative; height: 100px;"> 氏名 </div> </div>
	<div style="position: relative; height: 100px;"> 個人番号 </div>
	<div style="position: relative; height: 100px;"> 電話番号 </div>

治療していることを証明します。

This is the conclusion of the medical certificate stating that treatment is being provided - this will be completed by the medical institution, not by you.

セクション 4 — Section 4

1

治療していることを証明します。

2

年 月 日

3

所在地

4

医療機関の

5

名称

6

医師名

印

- 1

治療していることを証明します。
This is a statement that says 'I certify that [the patient] is receiving treatment.' This is typically pre-printed text that doesn't need to be filled in by you.
- 2

年 月 日 Year Month Day
Write the date in Japanese format (year/month/day) using Arabic numerals, e.g., 2024年12月15日
- 3

所在地 Location
Used for business/organization address or property location rather than personal residence
- 4

医療機関の Medical institution's
This appears to be an incomplete label - you may need to provide information about your medical institution or healthcare provider if the full field relates to insurance or medical registration.
- 5

名称 Name/Designation
Use for organization/business names rather than personal names
- 6

医師名 Doctor's name
Enter the full name of your attending physician or the doctor who issued medical documentation



COUNTER PHRASES

Point and show these to ward office staff

FINDING THE COUNTER

すみません、国民健康保険の窓口はどこですか？

Sumimasen, kokumin kenkō hoken no madoguchi wa doko desu ka?

Excuse me, where is the National Health Insurance counter?

ENROLLING

国民健康保険に加入したいのですが

Kokumin kenkō hoken ni kanyū shitai no desu ga

I would like to enroll in National Health Insurance

CANCELLING

国民健康保険をやめたいのですが

Kokumin kenkō hoken wo yametai no desu ga

I would like to cancel my National Health Insurance

SHOWING PROOF

資格喪失証明書を持っています

Shikaku sōshitsu shōmeisho wo motteimasu

I have my Certificate of Health Insurance Loss

ASKING ABOUT PREMIUMS

保険料はいくらですか

Hokenryō wa ikura desu ka?

How much is the insurance premium?

LEFT PREVIOUS JOB

会社を辞めたので、国保に切り替えたいです

Kaisha wo yameta node, kokuho ni kirikae tai desu

I left my company and want to switch to National Health Insurance