

Agreement of Authorization

• Starting date of medication Year_____ Month____ Day____

• Insured (Patient)

(Name of the insured) _____

(Address) _____

(Date of birth) Year_____ Month____ Day____

To: NAHA City Office

I (patient who has received treatment),_____ and my head of house hold, _____ authorize the City Office or its staff, and its subcontractors, including sub-subcontractors to refer and obtain any and all factual information related to an overseas medical treatment benefit claim(s) filed or to be filed including date of the treatment, place, and any treatment records and information from the medical organization in order to verify by submitting the related application forms.

Also, I agree to submit a photocopy of my passport if it is necessary along verification process written above.

Signature

Insured person who has received treatment shall sign one's signature. However, in the following case, guardian (insured person is under age), guardian of adult (insured person is adult ward), heir (insured person is dead) shall sign one's signature.

(Signature) _____ 印

(Address) _____

(Date) Year_____ Month____ Day____

(Relation to the insured) : Self •Guardian • Heir • Other

※ This agreement of authorization expires six month after the signed date.

Also, we might ask you to fill out the formatted documents if countries or regions, and medical institutions required submitting their format of agreement of authorization or authorization letter.