

# National Health Insurance

## Withdrawal Application Form for Category 6 Insured

As per Form 2

Date form filled in \_\_\_\_\_ (YYYY/MM/DD)

**A. The insured** ( Check  in the  when only applying for insurance withdrawal of the dependent, and also fill in the insured's National ID number, full name and dependency information. )

National ID number <small>(Alien Resident Certificate number)</small>	First Name	Date of birth			Reason for withdrawal	Date of occurrence		
		Year	Month	Day		Year	Month	Day
	Last Name				<input type="checkbox"/> C- Change of insured unit or change of insurable status <input type="checkbox"/> E- Missing for six months <input type="checkbox"/> M- Death <input type="checkbox"/> U- Loss of insurance eligibility			

**B. Dependent(s)**

National ID number <small>(Alien Resident Certificate number)</small>	First Name	Date of birth			Title	Code	Reason for withdrawal	Date of occurrence		
		Year	Month	Day				Year	Month	Day
	Last Name						<input type="checkbox"/> C- Change of insured unit or change of insurable status <input type="checkbox"/> E- Missing for six months <input type="checkbox"/> M- Death <input type="checkbox"/> U- Loss of insurance eligibility			

**C. Withdrawing person's original insured household address:**

Household address	Postal code								
Contact number	(Office)	(Home)	(Cellphone)						

**D. Fill in the information below if transferring to new insured unit:**

Name of new insured unit transferring to:	Insured unit's code	Contact number	Enrollment date		
			Year	Month	Day

**E. Signature or seal of the insured:** \_\_\_\_\_

**Signature or seal of the agent (principal):** \_\_\_\_\_



**F. Insured unit review result:**

Fields of this form match the documentation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Insured unit's stamp		Handling person's signature or seal
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Insured unit's code: 62000

Insured unit's name:

※ Turn over for directions when filling out form.

**Application form directions:**

I. When applying for insurance withdrawal for the insured or his/her dependent(s), the insured shall fill out a copy of this form and submit such to the local household registration office in the district where he/she resides; After review, signature and seal by handling personnel, a photocopy shall be made for the insured to take to the new insured unit for insurance procedures.

II. Check  in the  based on the reason for withdrawal:

- (I) Change of insured unit or change of insurable status: when the insured moves household registration; the insured or dependent converts to other insured or dependent category; dependent terminates adoption relationship, divorce, or descendant is 20 years old or more and not eligible for continuation of insurance.
- (II) Code U: Refers to expiration of residency; moving out of the household registration to stay abroad; loss of Republic of China nationality; etc.

III. Fill in dependent's title and code according to the following standards:

Code	1	2	3	4	5	6	7	8	9	0	p
Title	Spouse	Parent	Child	Paternal grandparent	Paternal grandchild	Maternal grandparent	Maternal grandchild	Paternal great-grandparent	Maternal great-grandparent	Veteran's other surviving dependent	Ward
In case of cross-degree of relationship insurance, attach relevant supporting documents or statements											

IV. When insured withdraws from insurance, his/her dependent shall also withdraw and then participate in the insurance as per other status. If the reason for withdrawal is that insured has been missing for six months, death, or loss of insurance eligibility, relevant supporting documents shall be attached for processing.

V. In order to protect the rights and interests of the insured, and to avoid double insurance and double-counting of health insurance premiums, when the insured or dependent transfers the insured unit and is unable to apply for insurance withdrawal at the rural village (township, city, district) office where the household is located, the new insured unit shall directly provide this form to be filled in by the insured transferring in. The insured shall also be asked to complete this form and submit with sufficient postage to the Social Welfare Section (or National Health Insurance Section) of the municipal office where the original household registration is located.

Submit via registered mail with sufficient postage

(Recipient)

(Sender's address)  
Name  
Address

Stamp