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| 支　給　決　定　伺 | | | | | | | | | | | | | | | | | | | | | | | | 支給決定　令和　　　年　　　月　　　日 | | | | | | | | | | | | | | | | |
| 付加給付 | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | 常務理事 | | | | 事務長 | | | 係 | | | 係 | | | |
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| 備考 | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | □ | | | **一部負担還元金** | | | | | | | | | | | | | | **申請書** | | | | | | | | | | | | | | | | | |
| □ | | | **家族療養費付加金** | | | | | | | | | | | | | |
|  | | | | | |  | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| 被保険者等 | | | |  |  | | |  | | - |  | | |  | |  | |  | |  | | 事業所の | | | | | | |  | | | | | | | □任意継続 | | | | | |
| 記号番号 | | | | 名称 | | | | | | |
| 資格取得年月日 | | | | 昭和・平成・令和　　　　　　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | 資格喪失年月日 | | | | | | | | 令和 | | 年　　　　月　　　　日 | | | | | | | | | |
| 療養を受けた方が | | | | その方の | | |  | | | | | | | | | | | | | | | 生年月日 | | | | | | | | 昭和・平成・令和　　　　年　　　月　　　日 | | | | | | | | | | | |
| 氏名 | | |
| 被扶養者であるとき | | | | 続柄 | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|
| 傷病名 | | | |  | | | | | | | | | | | | | | | | | | 診療を受けた年月 | | | | | | | | 令和 | | 年　　　月受診 | | | | | | | | | |
| 診療を受けた医療機  関の名称・所在地 | | | | 名称 | | |  | | | | | | | | | | | | | | | | | | | | | | | 自己負担額 | | | 円 | | | | | | | | |
|
| 所在地 | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| 当該処方箋に基づく薬  の購入先（調剤薬局）  の名称・所在地 | | | | 名称 | | |  | | | | | | | | | | | | | | | | | | | | | | | 自己負担額 | | | 円 | | | | | | | | |
|
| 所在地 | | |  | | | | | | | | | | | | | | | | | | | | | | |
|
|  |  |  |  | 上記の通り申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被保険者 | | | | 三井物産健康保険組合　理事長　殿 | | | | | | | | | | | | | | | | | | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | |
| 被保険者の住所 | | | | | | | | | | | 〒 | |  | | | | - | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名(フリガナ） | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
|  | |
| 日中連絡の取れる電話番号 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 委任状（退職後の任意継続の方以外は必ずご記入お願いいします） | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 付加給付の受領を | | | | | | | | |  | | | | | | | | | | | | | | | | | に委任いたします。 | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |  | |  | |
| 被保険者 | | | | | | |  | | | | | | | | | | | |  | |
| ※上段にお勤めの事業所名（会社名）、下段に被保険者名をご記入ください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 領収証（原本）  返却希望 | | | | 有　　・　　無 | | | | | | | | \*医療費控除の適用を受ける場合は、領収証原本を返却いたしますので「有」に○印をお付けください。  （必ず申請時にご指定ください。受理後の返却要請には応じられません。）  なお、**返却は国内住所宛または三井物産社内便のみとなりますので予めご了承ください。** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* | 太枠内にご記入ください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* | この申請は、薬局に支払った薬剤の自己負担額と、その処方箋を交付した医療機関に支払った医療費自己負担額の合計が21,000円以上に | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | なったときに行ってください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* | この申請書は、１ヶ月（暦月）ごとに作成してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 受付印 | | | |  | | |
| \*  \* | 医療機関発行の領収証（原本）を添付してください。  「事業所の名称」欄には、お勤めの事業所名・被保険者名をご記入ください。任意継続の方は□にチェックを入れてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* | 「委任状」欄には、お勤めの事業所名・被保険者名をご記入ください。任意継続の方は記入を要しません。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |