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| 支　給　決　定　伺 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 支給決定　令和　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 出産育児一時金 | | | 支給決定額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 常務理事 | | | | | | | | | | 事務長 | | | | | | | 係 | | | | | | 係 | | | | | | |  | | | |
| 円 | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | |  | | | | | | |  | | | |
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|  | | | | | | | | **□** | | | | **被保険者** | | | | | | | | **出産育児一時金請求書** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | **□** | | | | **家族** | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| 被保険者等 | | |  | |  | |  | | | - | | |  |  | | |  | |  | | | | |  | | | | 事業所の | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | □任意継続 | | | | | | | | |  | | | |
| 記号番号 | | | 名称 | | | | | | | | | | □喪失後請求 | | | | | | | | |  | | | |
| 資格取得年月日 | | | 昭・平・令 | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | 資格喪失年月日 | | | | | | | | | | | | | | 令和 | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | |  | | | |
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| 出産されたのが | | | その方の | | | | |  | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | | | | | | | | | | 昭和  平成 | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | |  | | | |
| 氏名 | | | | |  | | | |
| 被扶養者であるとき | | | 扶養 | | | | | 昭・平・令　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | \*扶養認定後6ヶ月以内又は資格喪失後6ヶ月以内の出産のときは下証明欄に健康保険機関の証明を受けてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 認定日 | | | | |  | | | |
| 出産年月日 | | | 令和 　 年　月　日 | | | | | | | | | | | | | | | | | | | | | | | 出生児数 | | | | | | | | | | | | | | | | | | | | | | | | 死産児数 | | | | | | | | | | | | | | | | | |  | | | |
| 人 | | | | | | | | | | | | | | | | | | | | | | | | 人 | | | | | | | | | | | | | | | | | |
| 出生児が被扶養者であるかどうか | | | 有・無 | | | | | | | | | | | | | | | | | | | | | | | | | 被保険者との続柄 | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | |
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|  | | | 上記の通り請求します。 | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 被保険者欄 | | | 三井物産健康保険組合　理事長　殿 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 被保険者の住所 | | | | | | | | | | | | | 〒 | | | | | | | | | | | | | | | | | - | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| 氏名(フリガナ） | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
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| 日中連絡の取れる電話番号 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| 委任状（任意継続の方・資格喪失後の請求のときには記入を要しません。） | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 法定給付の受領を | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | に委任いたします。 | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| ※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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | 出産年月日 | | | | | | | 令和　　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | 生産・死産の別 | | | | | | | | | | | 生　　産　　・　　死　　産 | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| （妊娠第　　　月又は　　　週） | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 医師又は  助産師の  証明 | | | 出生児数 | | | | | | | 単胎・多胎（　　　胎） | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 上記のとおり相違ないことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 令和　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | 医療施設の名称・所在地 | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | |
|  | | |  | | | 医師・助産師 | | | | | | | | | | | | | | |  | | | |
| \***被扶養者認定後6ヶ月以内**の出産で家族出産育児一時金を請求するときには以前加入していた健康保険機関で、又、**資格喪失後6ヶ月以内**の出産で被保険者出産育児一時金を請求するときには現在加入している健康保険機関で次の証明を受けてください。尚、認定後6ヶ月以内の出産で、以前ご加入の機関が国民健康保険の場合は証明は不要ですので下欄の該当箇所にチェックを入れ、自治体名をご記入ください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| 健康保険組合・社会保険事務所又は共済組合証明欄 | | | 旧（又は現）被保険  者証の記号番号 | | | | | | | |  | | | | | | | 氏名 | | | | | | | （旧姓　　　　　　　　） | | | | | | | | | | | | | | | | | | | | 出産 | | | | | | | | 令和　　　年　　月　　日 | | | | | | | | | | | | | | |  | | | |
| 年月日 | | | | | | | |  | | | |
| 資格取得(又は認定） | | | | | | | | 令和　　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | 資格喪失  年月日 | | | | | | | | | | | 令　和　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 年月日 | | | | | | | |  | | | |
| 上記について出産育児一時金（家族出産育児一時金）を支給していないことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | |
| 令和　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | 名称 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | 氏名 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | |
|  | | | □国民健康保険加入（自治体：　　　　　　　　　　　　　　　区・市・町・村） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |
| 振込先（資格喪失後6ヶ月以内の請求の方のみご記入ください。） | | | 金融機関 | | | | |  | | | | | | | | | | | | | | | | | | | | 銀行 | | | | | | | 口座番号 | | | | | | |  | | | |  | | | |  | | |  | |  | |  | |  | | | | |  | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | 支店 | | | | | | | 種別 | | | | | | | 普　通　・　当　座 | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| 名義（漢字） | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | 名義（ｶﾅ） | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| \* | 太枠内にご記入いただき、各種証明を受けてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
| \* | 「事業所の名称」欄には、お勤めの（であった）事業所名をご記入ください。任意継続の方、資格喪失後に請求される　　　　受付印  方は該当の□にチェックを入れてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| \* | 「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。なお、任意継続の方は記入を要しません | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| \* | 資格喪失後の請求のとき（任意継続であった方を除く）には「振込先」欄に振込みご希望の金融機関名をご記入ください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| \* | 医療機関等によって直接支払制度を利用していない旨の記載がなされた出産費用の領収証をご提出ください。  （産科医療補償制度に加入する医療機関等で出産された場合には、その旨を証するスタンプが押されていることをご確認ください。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |