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| 支　給　決　定　伺 | | | | | | | | | | | | | | | | | | | | | | | | | | | 支給決定　令和　　年　　　月　　　日 | | | | | | | | | | | | |  | | |  | |
| 法定給付 | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | | | 常務理事 | | | | 事務長 | 係 | | | | 係 | |  | | |  | |
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| 備考 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
|  | | | | | | **□** | | | **被保険者** | | | | | | | | **移送費支給申請書** | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
| **□** | | | **家族** | | | | | | | |  | | |  | |
| 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 | | | | | | | |  | | |  | |
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| 移送対象者が | | 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 | | |  | | | | | | | | | | | | | | | | | 発病又は負傷の | | | | | | | | 令和 | | 年　　　　月　　　　日 | | | | | | | |  | | |  | |
| 年月日 | | | | | | | |  | | |  | |
| 傷病名 | |  | | | | | | | | | | | | | | | | | | | | 傷病の原因 | | | | | | | |  | | | | | □不詳 | | | | |  | | |  | |
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| 負傷原因の第三者行  為「該当」「非該当」の  別/「該当」の場合 加  害者の住所・氏名 | | 負傷原因は第三者行為に　□該当　　□非該当　　（「該当」の場合には加害者の住所・氏名を記載してください。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
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| 移送に要した費用 | | 円 | | | | | | | | | | | | | | | | | | | | 移送日 | | | | | | | | 令和 | | 年　　　　月　　　　日 | | | | | | | |  | | |  | |
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| 移送の方法 | |  | | | | | | | | | | | | | | | | | | | | 移送の経路 | | | | | | | | から | | | | | | | | | |  | | |  | |
| 迄 | | | | | | | | | |  | | |  | |
| 付添い人の有無/ | | 付添い人は　　□有　　□無　　（「有」の場合には付添い人の住所・氏名を記載してください。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
| 「有」の場合その方の | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
| 住所・氏名 | |  | | |  | |
| 医師の意見 | | 傷病名 | | | | |  | | | | | | | | | | | | | | | | | | 移送年月日 | | | | | | 令和 | | 年　　　　月　　　　日 | | | | | | |  | | |  | |
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| 移送及び付き  添いが必要と  認めた理由 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
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| 移送の方法 | | | | |  | | | | | | | | | | | | | | | | | | 移送の経路 | | | | | | から | | | | | | | | |  | | |  | |
| 迄 | | | | | | | | |  | | |  | |
| 移送先医療機  関の名称及び  住所 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
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| 上記のとおり相違ないことを証明します。 | | | | | | | | | | | | | | | | | | | 令和　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | |  | | |  | |
|  | 医療機関の名称・所在地 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | |
|  | 医師の氏名 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |
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|  | | 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 | | | | | | | | | | | 〒　　　　　　　- | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | |
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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（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） | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | |
| 法定給付の受領を | | | | | | | | | | 在籍している事業所 | | | | | | | | | | | | | | に委任いたします。 | | | | | | | | | | | | | |  | |  | | |
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|  | | | | | | | | | | | | | | | | | 被保険者 | | | | |  | | | | | | | | | | | | |  |  | |  | |
| ※下段に被保険者名をご記入ください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
| 領収証（原本） | | 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。** | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
| 返却希望 | |  | | |  | |  | |
| \* | 太枠内にご記入いただき、医師の証明を受けてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
| \* | 「事業所の名称」欄には、お勤めの事業所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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 受付印 | | | | |  | | |
| \* | 「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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
| \* | 傷病の原因がはっきりしないときには「不詳」にチェックを入れてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |