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| 支　給　決　定　伺 | | | | | | | | | | | | | | | | | | | | | | | | 支給決定　令和　　　年　　　月　　　日 | | | | | | | | | | | | | | |
| 法定給付 | | | | | | | 円 | | | | | | | | | | | | | | | | | 支給割合　：　□7割　□8割　□9割 | | | | | | | | | | | | | | |
| 付加給付 | | | | | | | 円 | | | | | | | | | | | | | | | | | 常務理事 | | | | 事務長 | | 係 | | | | | 係 | | | |
| 支給基準額 | | | | | | | 円 | | | | | | | | | | | | | | | | |  | | | |  | |  | | | | |  | | | |
| 疾病別点数資料№（海外） | | | | | | |  | | | | | | | | | | | | | | | | |
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|  | | | | □ | | | **療養費** | | | | | | | | | | | | | | **（付加金）申請書** | | | | | | | | | | | | | | | | | |
| □ | | | **家族療養費** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | |  | | | | | | | | | | | | | | | | | 傷病の原因 | | | | | |  | | | | | | | □不詳 | | | | | | |
| 診療を受けた医療機関の名称・所在地 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|
| 診療に要した費用 | | 円 | | | | | | | | | | | | | | | | | | 診断の期間 | | | | | |  | | | | | | | | | | | | |
| 令和　　　　年　 　月　 　日 | | | | | | | | | | | から | |
| 令和　　　　年　 　月　 　日 | | | | | | | | | | | まで | |
| 日間（診療実日数） | | | | | | | | | | | | |
| 保険診療を受けられな  かった理由 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|
| 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。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|
|  | | 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  の方以外は記入お願いします） | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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。 | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | |  |
|  | | | | | | | | | | | | | | 被保険者 | | | | | |  |
| ※下段に被保険者氏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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* | 「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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 受付印 | | | | |  | | |
| \* | 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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |