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| 健保記入欄 | 支給決定伺 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 支給決定　令和　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 支給決定額 | | | | | 円 | | | | | | | | | | | | | | | | | | | | | 常務理事 | | | | | | 事務長 | | | | | | 係 | | | | | | | 係 | | | | | | | | 係 | | | | | |
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| 支給期間 | | | | | 令和　　 年　　　月　　　日から | | | | | | | | | | | | | | 日間 | | | | | | |
| 令和　　 年　　　月　　　日まで | | | | | | | | | | | | | |
| 標準報酬月額 | | | | | 千円 | | | | | | | | | | | | | | | | | | | | | 法第９９条による待期期間 | | | | | | | | | | | | | | | | | | | | | | 有　・　無 | | | | | | | | | | |
| 算出基礎 | | | | | 日額 | |  | | | 円× | | | | | 2/3 | | | | | | × | | |  | | | | | | 日＝ | | | | |  | | | | | | | | | | | | | | | | | | | | | 円 | | |
| 調整 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 備考 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | 傷　病　手　当　金　請　求　書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 〔第　　　回〕 | | | | | | | | | | | | | | | |
| 被保険者記入欄 | 被保険者等  記号番号 | |  | | | | | | | － | |  | | | | | | | | | | | 事業所の  名称 | | | | | | | | | | |  | | | | | | | | | | | | | | □ | | | 任意継続 | | | | | | | | |
| □ | | | 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 | | | | | | | | | | | | | | | | | | | |
| 傷病名 | |  | | | | | | | | | | | | | | | | | | | | 発病又は負傷  の年月日 | | | | | | | | | | | 年　　月　　日頃 | | | | | | | | | | | | | | | | | | □不詳 | | | | | | | |
| 発病又は負傷  の原因 | |  | | | | | | | | | | | | | | □不詳 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 療養のため  休んだ期間 | | 令和　　　年　　　月　　　日から | | | | | | | | | | | | | | | 日間 | | | | | 左記の期間に  報酬を | | | | | | | | | | | 受けた　・　受けない | | | | | | | | | | | | | | | | | | | | | | | | | |
| 令和　　　年　　　月　　　日まで | | | | | | | | | | | | | | |
| 報酬を受けた | | 令和　　　年　　　月　　　日から | | | | | | | | | | | | | | | 日間 | | | | | 報酬の額 | | | | | | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 場合その期間 | | 令和　　　年　　　月　　　日まで | | | | | | | | | | | | | | |
| 労災保険から休業補償給付を受けていますか。または過去に受けたことがありますか。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □受けている又は受けることができる　□請求中（以上を選択した方は下欄にご記入ください。）　□受けていないし、受けることもできない | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 支給元（請求先）の労働基準監督署をご記入ください。（　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　労働基準監督署） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 障害年金又は障害手当金、老齢年金、その他退職を事由とする公的年金を受けているか、受けることができる状況にありますか。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □受けている又は受けることができる　□請求中（以上を選択した方は下欄にご記入ください。）　□受けていないし、受けることもできない | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 障害年金又は障害  手当金を  受けているとき又  は受けることがで  きるとき | | | 年金の種別 | | | | | | 障害年金  障害手当金 | | | | | | | | | 年金額 | | | | | 円 | | | | | | | | | | | | 年金証書の  受給番号 | | | | | | | | |  | | | | | | | | | | | | | | |
| 受給の原因と  なった傷病名 | | | | | |  | | | | | | | | | | | | | | 年金を受けること  となった年月日 | | | | | | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | |
| 老齢年金・ 退職を事由 とする 公的年金を受 けているとき 又は 受けることが できるとき | | | 受給の状況 | | | | | | 請　求　中　　・　　受　給　中 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 老齢（退職）年金の名称 | | | | | | | | | | | 基礎年金番号・年金コード等 | | | | | | | | | | | | | 受給年月日 | | | | | | | | | | | | | | 年金額 | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | 平・令　　　年　　月　　日 | | | | | | | | | | | | | | 円 | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | 平・令　　　年　　月　　日 | | | | | | | | | | | | | | 円 | | | | | | | | | | | | | | | | | |
| 上記の通り請求します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 三井物産健康保険組合　理事長　殿 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 令和　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被保険者 | | 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・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 | | | | | | | | | 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 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
| ※下段に被保険者氏名をご記入ください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 振込先（資格喪失後  の請求のときのみ必ずご記入ください。） | | 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） | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |

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| 事業主の証明欄 | 労務に服さな | | | 令和　　　　年　　　　月　　　　日から | | | | | | | | | | | | | | | | | | | | | 日間 | | | | | | |  | | | | | | | | | | | | |
| かった期間 | | | 令和　　　　年　　　　月　　　　日まで | | | | | | | | | | | | | | | | | | | | |
| 出勤は○で、有給は△で、公休は公で、欠勤は／でそれぞれ記入して下さい。 計　出勤：　　日　有給：　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　月 | | | 1 | 2 | | 3 | 4 | | | 5 | 6 | 7 | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | | 15 | 16 | | 17 | 18 | 19 | | 20 | 21 | | 22 | | 23 | 24 | 25 | 26 | | 27 | 28 | 29 | 30 | 31 |
| 年　　月 | | | 1 | 2 | | 3 | 4 | | | 5 | 6 | 7 | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | | 15 | 16 | | 17 | 18 | 19 | | 20 | 21 | | 22 | | 23 | 24 | 25 | 26 | | 27 | 28 | 29 | 30 | 31 |
| 年　　月 | | | 1 | 2 | | 3 | 4 | | | 5 | 6 | 7 | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | | 15 | 16 | | 17 | 18 | 19 | | 20 | 21 | | 22 | | 23 | 24 | 25 | 26 | | 27 | 28 | 29 | 30 | 31 |
| 上記期間中の  分として  支払う金額 | | | 令和　　　　年　　　　月　　　　日から | | | | | | | | | | | | | | | | | | | | | 日間 | | | | | | | 全額 | | | | | | |  | | | | | |
| 令和　　　　年　　　　月　　　　日まで | | | | | | | | | | | | | | | | | | | | |
| 令和　　　　年　　　　月　　　　日から | | | | | | | | | | | | | | | | | | | | | 日間 | | | | | | | 一部支給 | | | | | | | 円 | | | | | |
| 令和　　　　年　　　　月　　　　日まで | | | | | | | | | | | | | | | | | | | | |
| 令和　　　　　年　　　　　月　　　　　日　より無給 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記のとおり相違ないことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 令和　　　　　　年　　　　　　月　　　　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 事業主 | | | | 住所 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | 氏名 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 療養を担当した医師の意見 | 傷病名 | | |  | | | | | | | | | | | | | | | | | | 傷病又は  負傷の原因 | | | | | | |  | | | | | | | | | | | | | | | |
| 発病又は負傷  の年月日 | | | 平・令 | | | | | 年　　　月　　　日 | | | | | | | | | | | | | 療養の給付  開始年月日 | | | | | | | 平・令 | | | | | 年　　　月　　　日 | | | | | | | | | | |
| 労務不能と  認めた期間 | | | 令和　　　年　　　月　　　日から | | | | | | | | | | | | | | | | | | 労務不能期間  中の診療日数 | | | | | | | 日間 | | | | | | | | | | | | | | | |
| 令和　　　年　　　月　　　日まで | | | | | | | | | | | | | | | | | |
| 傷病の主症状  及び経過概要 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記の通り相違ありません | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 令和　　　　　　　年　　　　　　　月　　　　　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 医療機関の名称・所在地 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 医師の氏名 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ＊ | 太枠内にご記入いただき、各種証明を受けてください。 | | |
| ＊ | この様式は被保険者が傷病の為に会社の勤務を休み、休んだ期間の報酬等の支払を減額又は受けられない場合に請求するものです。 | | |
| ＊ | この請求をするときは「療養を担当した医師の意見」の証明を受け、次に事業主の証明を受けて、組合に提出してください。 | | |
| ＊ | 傷病手当金は給与に代わって支給するものですので、請求は月単位又は給与の〆日単位で行ってください。 | | |
| ＊ | 事業所の担当の方は、提出の際に賃金台帳の写と出勤簿の写を添付してください。 | | |
| ＊ | 上記の賃金台帳の写には賃金の〆日と支払日を記載してください。 | | |
| ＊ | 公的年金の受給者は年金額がわかる書類の写を添付してください。 | | |
|  | | | |
|  |  | 受付印 |  |

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