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| 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 | | |  | | | |  | | | | |
| 支給期間 | | | 令和 | | | | 年　　　　月　　　　日から | | | | | | | | | | | | | | | | 日間 | | | | | | 標準報酬  月額 | | | | | 千円 | | | | | | | | | | |  | | | | | | | |  | | | | |  | | | | | | | | |  | | |  | | | |  | | | | |
| 令和 | | | | 年　　　　月　　　　日まで | | | | | | | | | | | | | | | |  | | | |  | | | | |
| 算出基礎 | | | 日額 | | | |  | | | | | 円×2/3× | | | | | | | | | | |  | | | | | | 日= | | | | |  | | | | | | 円 | | | | | 備考 | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | |
|  | | | | | | | | | | | | | | | **出産手当金請求書** | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | |
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| 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 | | | | | 令和　　年　　月　　日 | | | | | | | | | | | | | | | | | | 出産 | | | | | | 令和　　年　　月　　日 | | | | | | | | | | | | | | | | | | | 胎児 | | | | | | 単胎・多胎（　　　児） | | | | | | | | | | | | |  | | | | | | | |  |
| 年月日 | | | | | 予定日 | | | | | | の数 | | | | | |  | | | | | | | |  |
| 出産・休業 | | | 出産のため | | | | | | | 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | から | | | | | | 日間 | | | | | | | 左記の期間に | | | | | | | | | | | 受けた・受けない | | | | | | | | | | | | |  | | | | | | | |  |
| 及び報酬について | | | 休んだ期間 | | | | | | | 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | まで | | | | | | 報酬を | | | | | | | | | | |  | | | | | | | |  |
|  | | | 報酬を受けた | | | | | | | 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | から | | | | | | 日間 | | | | | | | 報酬 | | | | | | | | | 円 | | | | | | | | | | | | | | |  | | | | | | | |  |
| 場合その期間 | | | | | | | 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | まで | | | | | | の額 | | | | | | | | |  | | | | | | | |  |
|  | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  |
| 被保険者の住所 | | | | | | | | | | | | | | | 〒 | | | |  | | | | | | | | | - | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  |
| 被保険者 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  |
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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・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  6ヶ月以内の請求のときの  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） | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
|  | | | 労務に服さな  かった期間 | | | | | | | 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | から | | | | | | 日間 | | | | | | | 左記の期間の | | | | | | | | | | | 有　　・　　無 | | | | | | | | | | | | |  | | | | |  | | | |
| 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | まで | | | | | | 報酬の | | | | | | | | | | |  | | | | |  | | | |
| 事業主証明欄 | | | 報酬支給 | | | | | | | 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | から | | | | | | 日間 | | | | | | | 報酬 | | | | | | | | | 円 | | | | | | | | | | | | | | |  | | | | |  | | | |
| 対象期間 | | | | | | | 令和 | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | まで | | | | | | の額 | | | | | | | | |  | | | | |  | | | |
| 上記のとおり相違ないことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
|  | | | 令和　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | | | 事業主（又は代理人） | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | 所在地 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | | | |  | | | |
| 氏名 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
|  | | | 出産年月日 | | | | | | | 令和　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | 出産予定日 | | | | | | | | | | | | 令和　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
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| 分娩の | | | | | 正常　・　異常 | | | | | | | | | | | | 胎児 | | | | | | 単胎　・　多胎（　　　児） | | | | | | | | | | | | | | | | 生産・死産 | | | | | | | | | 生　　産　　・　　死　　産 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
| 医師又は | | | 状態 | | | | | の数 | | | | | | の別 | | | | | | | | | （妊娠第　　　　月又は　　　　週） | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
| 助産師の | | | 上記のとおり相違ないことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
| 証明 | | | 令和　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
|  | | |  | | 医療施設の名称・所在地 | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | |  | | | | |  | | | |
|  | | 医師・助産師 | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | |  | | | | |  | | | |
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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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |
| \* | 「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、資格喪失後の請求の | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 受付印 | | | | | | | | | |  | | | | | | |
|  | 方は該当の□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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | |
| \* | 資格喪失後の請求のとき（任意継続であった方を除く）のみ「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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | |
| \* | 医師又は助産師の証明と事業主の証明を受けて、組合に提出してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | |
| \* | 任意継続の方、資格喪失後6ヶ月以内の出産のために請求をされる方は事業主の証明は不要ですが、出産（予 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | |
|  | 定）日以前42日に事業所に在籍中であった方は必ず事業主の証明を受けてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | |