様式第1号(第2条関係)

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| ひとり親家庭等医療費受給資格認定(更新)申請書  　　年　　月　　日  　永平寺町長　　　　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申請者  （受給者） | | | | | | | | | | | | | | | | | 住所  氏名  電　話 | | | | | | | | | | | | | | |
| 次のとおり、ひとり親家庭等医療費受給資格認定(更新)を受けたく申請いたします。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 助成対象者 | 区分 | 氏名 | | | | | | | | | | | | | | 性別 | 続柄 | | | 生年月日 | | | | | | 職業 | | | | | |
| 個人番号 | | | | | | | | | | | | | |
| 母（父） |  | | | | | | | | | | | | | |  |  | | | 年　月　日 | | | | | |  | | | | | |
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| 受給者 | 氏　名 |  | | | | | | | | | | | | | | | 資格要件 | | |  | | | | | | | | | | | |
| 住　所 | 永平寺町 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医療保険 | 保険名称 |  | | | | | | | | | | | | | | 種別被保 |  | | | | | | | | | | | | | | |
| 記号番号 |  | | | | | | | | | | | | | | 附加給付 | 有・無 | | | | | | | | | | | | | | |
| 世帯主、被保険者又は組合員指名 | | | | |  | | | | | | | | | | 取得日 | 年　　月　　日 | | | | | | | | | | | | | | |
| 口座 | 金融機関 | 銀行・信金  農協・労金 | | | | | | | | | | | | | | 口座番号 | （普・当） | | | | | | | | | | | | | | |
| 支店名 | 本店  支店 | | | | | | | | | | | | | | （フリガナ） |  | | | | | | | | | | | | | | |
| 名義人 |
| 扶養義務者等 | 氏名 | | | | | 性別 | | | | | 続柄 | | | | | 生年月日 | | 個人番号 | | | | | | | | | | | | | |
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注意　①　※欄は記入しないで下さい。

　　　　②　加入医療保険が受給者と児童と異なる場合は、その旨申し出てください。

※《役場記入欄》

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| 受付日 | 年　　月　　日 | 備考 |
| 認定日 | 年　　月　　日 |