様式第２号の３(第６条関係)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 介護保険　資格者証等再交付申請書  　福島市長  　次のとおり申請します。   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | 申請年月日 | | 年　　　月　　　日 | | | | | | | | | | | 被保険者 | フリガナ |  | | 被保険者番号 | |  |  |  |  |  |  |  |  |  |  | | 氏名 |  | | | 生年月日 | □明治　□大正　□昭和　　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | 住所 | 電話番号　　　　　（　　　　　） | | | | | | | | | | | | | | | 再交付する証明書 | | １　資格者証　　　 ２　受給資格証明書 | | | | | | | | | | | | | | | 申請理由 | | １　紛失・焼失 | ２　破損・汚損 | | ３　その他（　　　　　　　　　　　　） | | | | | | | | | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 窓口に来られた方 | □ | 本　人 | | | | | □ | 家族等の方（氏名等を記入してください。） | | | | |  | フリガナ |  | 被保険者との  関係 |  | | 氏名 |  | | 住所 | 〒  電話番号　　　　　（　　　　　） | | |   第２号被保険者（４０歳から６４歳までの医療保険加入者）の方は、下欄にご記入ください。   |  |  | | --- | --- | | 医療保険者名 |  | | 医療保険被保険者  証記号番号 |  |      |  |  |  |  | | --- | --- | --- | --- | | 保険者使用欄 | | | | | 受付年月日 | 年　　　月　　　日 | データ入力 |  | |