**様式第４号**（第６条関係）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 介護保険　被保険者証等再交付申請書  　盛岡北部行政事務組合  　管理者　様  　次のとおり申請します。   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | | | | | | | | | | | | | | | | | 申請年月日 | | | | 年　　月　　日 | | 申請者氏名 | |  | | | | | | | | | | | | | | | | | | | | | | 本人との関係 | | | |  | | 申請者住所 | | 〒  　　　　　　　　　　　　　　　　　　　　電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | ※申請者が被保険者本人の場合、申請者住所･電話番号は記載不要 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 被保険者 | 被保険者番号 | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | | | | | 個人番号 | |  |  | |  | |  | |  | |  |  |  | | |  | |  | |  | |  | | | フリガナ | |  | | | | | | | | | | | | | | | | | | | | | | | 氏名 | |  | | | | | | | | | | | | | | | | | | | | | | 生年月日 | | 年　　月　　日 | | | 性別 | | 男　・　女 | | | 住所 | | 〒  　　　　　　　　　　　　　　　　　　　　電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 再交付する証明書 | | | １　被保険者証　　２　資格者証　　　３　受給資格証明書  ４　負担割合証 | | | | | | | | | | | | | | | | | | | | | | | | | | | 申請の理由 | | | １　紛失・焼失　　２　破損・汚損　　３　その他（　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | ※２号被保険者（40歳から64歳の医療保険加入者）のみ記入 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医療保険者名 | | |  | | | | | | | | | | | | | 医療保険被保険者証記号番号 | | | | | | | | | |  | | | |