健康保険　被保険者/家族 埋葬料(費)請求書



**事業所担当者印**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **被　　保　　険　　者　　が　　記　　入　　す　　る　　と　　こ　　ろ** | **被保険者証の** | | | | | | | | | | | | | | | | | | | | | | | | | | | **③生 年 月 日** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | |  | | | | | |  | | |
|  | **①記号** | | | **②番号** | | | | | | | | | | | | | | | | | | | | | | | | **昭和**  **平成** | | | | | | | | | |  | | | | | **年** | | |  | **月** | | | |  | | | | **日** | | | |  | | | | | | | | | |  | | | | | | | |  | | | | | |  | | |
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|  | **④**  **被保険者の**  **（請求者）**  **氏名と印** | | | | | | **（フリガナ）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **事業所の** | | | | **名　　称** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **所在地** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **被保険者の**  **（請求者）**  **住所** | | | | | | **郵便番号** | | | | | **－** | | | | | | | | | | | | | | | | | **（フリガナ）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **（電話番号）** | | | | | | | | | | |
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|  | **死亡した年月日** | | | | | | | | **令和** | |  | | | | **年** | | |  | | | | | **月** | | |  | | | | | | | **日** | | | | **死亡原因** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | **⑤第三者の行為によるものですか** | | | | | | | | | | | | | | | | | | |
| **いいえ　・　はい** | | | | | | | | | | | | | | | | | | |
|  | **被扶養者が死亡した**  **ための請求である**  **ときは、その方の** | | | | | | | | **⑥被扶養者**  **氏名** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | **⑦生年**  **月日** | | | | **昭和**  **平成**  **令和** | | | | | |  | | **年** | | | |  | | | **月** | | | |  | | | **日** | | **⑧被保険者**  **との続柄** | | | | | | | | |  | | | | |
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|  | **被保険者が死亡した**  **ための請求である**  **ときは、その方の** | | | | | | | | **⑨被保険者**  **氏名** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | **⑩被保険者と**  **請求者の**  **身分関係** | | | | | | | |  | | | | | | | | | | | | | | | | **⑪被保険者の**  **標準報酬**  **月額** | | | | | | | | | | | **千円** | | | | | | |
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|  | **⑫埋葬した**  **年月日** | | | | | | | | **令和** | | | | |  | | | **年** | |  | | | | | | | **月** | |  | | | **日** | | | | | **⑬埋葬に要し**  **た費用の額** | | | | | | | | **円** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **老人保健法の医療**  **を受けていたとき** | | | | | | | | **⑭区市町村番号** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **⑮受給者番号** | | | | | | | | | | | | | | | | | | | | | | | | | | **⑯発行機関名** | | | | | | | | | | | | | | | | | | | | | |
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|  | **資格喪失後家族の被扶養者となったと**  **きは、その被保険者証の**  **被扶養者がコスモ石油健康保険組合の**  **資格を取得して6ヶ月以内の場合は、**  **資格を取得する直前の被保険者証の** | | | | | | | | | | | | | | | | | | | **保険者名、**  **記号および**  **番号**  **電話番号** | | | | | | | | | | | | | | | **保険者名** | | | | | | | | | | | | | | | | | | **記号　－番号** | | | | | | | | | | | | | | | | | | | | **電話番号** | | | | | | | | | | | | |
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|  | **（備考）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  |  | | --- | --- | | **委任状** | **コスモ石油健康保険組合理事長殿　　　　　　　　　　　　　　　　　　平成　　　　　　年　　　　　　月　　　　　　日**  **上記のとおり申請いたします。**  **上記により支給される金額の受領を事業主に委任いたします。**  **被保険者　　住所**  **氏名　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　㊞** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **支払金融機関の欄** | **⑰**  **本店**  **支店**  **銀行**  **金庫**  **農協** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **⑱**  **普 通**  **当 座** | | | | | | | | | | | | | **口座番号** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **口座名義** | | | | **（フリガナ）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **事業主が証明する欄** | | **死亡した**  **者の氏名** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | **死亡した者** | | | | | | | | | | **被保険者**  **被扶養者** | | | | | | | | | | | | | | **死亡した**  **年月日** | | | | | | | | **令和　　　　年　　　月　　　日死亡** | | | | | | | | | | | | | | | | | | | | | | | |
|  | **⑲　上記のとおり相違ないことを証明する。**  **年　　　　　　月　　　　　　日**  **住　　　所　　〒　　　 　　－**  **事業主**  **氏　　　名　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　電話　　　　　　　　（　　　　　　　　）　　　　　　　　　　　　番** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | | **支　　給　　金　　額** | | | | | | |  | **提出　　　　　年　　　　月　　　　日** | | |
|  | **法定給付** | |  |  |  |  |  |  |  |  |  | |
| **【添付書類】**  **埋葬料請求（下記のいずれか１つ）**  **・埋葬許可証または火葬許可証のコピー**  **・死亡診断書、死体検案書等のコピー**  **・亡くなった方の戸籍(除籍)謄(抄)本**  **※本人死亡の場合は⑲に記載あれば不要**  **埋葬費（下記両方の原本）**  **・領収書原本（支払者のフルネームおよび埋葬に**  **要した費用額が記載されたもの）**  **・埋葬に要した費用の明細書** | **付加給付** | |  |  |  |  |  |  |  |  |  |
| 常務理事  事務長  係  **コスモ石油健康保険組合** | **合計** | |  |  |  |  |  |  |  |  |  | |

被保険者

家　　　族