様式第１号（第４条関係）

Application for Issuance of Certificate of Eligibility for Children's Medical Aid

子ども医療費受給資格証交付申請書

I hereby apply for eligibility for Children's Medical Fee Aid.
I give my consent for the city to confirm the residency status, etc. of the beneficiary and the child from public records in order to confirm eligibility for the Children's Medical Fee Aid Certificate.
For elementary school students: from the first April 1st following the day after they turn 6, to the first March 31st following the day after they turn 12.
For junior high school students: from the first April 1st following the day after they turn 12, to the first March 31st following the day after they turn 15.

Eligible Child 助成対象子ども	ふりがな		Date of Birth 生年月日	Year年　Month月　Day日	
	Name 氏名		Age 年齢	Years歳	
	Address 住所	①Izumo shi 出雲市			
Beneficiary (primary provider) 受給資格者（主たる生計中心者）	ふりがな		Date of Birth 生年月日	Year年　Month月　Day	
	Name 氏名				
	Address 住所	□Same as ① ①と同じ		Relation to the eligible child 助成対象子どもとの続柄	Father / Mother / other （　　）
	Telephone 電話番号	（　　）　　－			

Insurance Information 加入保険	Name of the Insured Person 被保険者氏名	Paste the copy of the health insurance card of the eligible child here 助成対象子どもの健康保険被保険者証のコピー貼り付け欄
	Insurance Card Number 被保険者証の記号番号	
	Type of Insurance 保険種別	協・組・船・共・国 Additional Benefits 附加給付金の有無 Yes有　・　No無
	Insurance Company Name 保険者名	

Reason for application 資格証交付申請区分	1．Elementary school・Junior high school. 小学生・中学生（助成対象となったため） 2．Moved　転入したため 転入してきたため 3．Other その他（　　） (Date of Applicatio 交付事由発生年月日 :　Year年　Month月　Day日)

I hereby apply for issuance of Certificate of Eligibility for Children's Medical Aid.
上記のとおり、子ども医療費受給資格証の交付を申請します。

Year年　Month月　Day日

Applicant　申請者
□ Same as Beneficiary.　受給資格者と同じ
Address　住所
Name　氏名
Telephone　電話番号（　－　－　）

Mayor of Izumo City
出雲市長　様

受付　□保険証確認　協・組・船・共・国

※Please make sure to attach a copy of the child's health insurance card.
子どもの健康保険証のコピーを必ず添付してください

受付	照合