様式第７号－２

第三者行為による傷病届

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 被保険者 | 保険者番号 | | | | |  | |  |  |  | |  |  | |  | |  | 医療種別 | | | | 後期高齢者医療(給付割合　割) | | | | | | | | | | | | | | | | | | | | | |
| 被保険者番号 | | | | |  | |  |  |  | |  |  | |  | |  | 個人番号 | | | |  | |  | | | |  |  | |  | |  | | |  | |  |  | |  |  |  |
| 氏名 | フリガナ | | | |  | | | | | | | | | | | | | | | 生年月日 | | | | | | 大正  昭和 | | | | | 年　　月　　日 | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 性別 | | | | | | 男・女 | | | | | | | 年齢 | | | | | | 歳 | | | |
| 住所 | 〒　　　―  (電話)　　　　　―　　　― | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 第三者(相手方) | 氏名 | フリガナ | | | |  | | | | | | | | | | | | | | | 生年月日 | | | | | | 大正 昭和  平成 令和 | | | | | | | | 年　　月　　日 | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 性別 | | | | | | 男・女 | | | | | | | 年齢 | | | | | | 歳 | | | |
| 住所 | 〒　　　―  (電話)　　　　　―　　　― | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 勤務先 | | | | (電話)　　　　　―　　　― | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 自賠責 | 有・無　　　　　　　　　　　保険 | | | | | | | | | | | | | | | | 証明書番号 | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 契約者 | 氏名 |  | | | | | | | | | | 住所 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 任意 | 有・無　　　　　　　　　　　保険 | | | | | | | | | | | | | | | | 証券番号 | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 車検証 | 所有者 | 氏名 |  | | | | | | | | | | 住所 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 使用者 | 氏名 |  | | | | | | | | | | 住所 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 車両番号 | | | | | ナンバープレート | | | |  | | | | | | | | 車台番号 | | | |  | | | | | | | | | | | | | | | | | | | | |
| 事故概要 | 届出警察署 | | |  | | | | | | | | | | 発生日時 | | | | | 年　　月　　日 | | | | | | | | | | | 午前  午後 | | | | | | | 時　　分 | | | | | | |
| 場所 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 事故状況 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療 | 病院名  薬局名 | | |  | | | | | | | | | | | | | | | 初診日 | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | |
| 保険診療開始日 | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | 初診日 | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | |
| 保険診療開始日 | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | 初診日 | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | |
| 保険診療開始日 | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | |
| 上記のとおり届けます  　　　　　年　　　月　　　日  　　愛媛県後期高齢者医療連合長　様 | | | | | | | | | | | | | | | | | | | | 届出者  (被保険者) | | | | | | 住所  氏名　　　　　　　　　　印 | | | | | | | | | | | | | | | | | |