第２号様式(第２条関係)

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| 介護保険住所地特例適用・変更・終了届  　　（宛先）鈴鹿亀山地区広域連合長  　次のとおり住所地特例(適用・変更・終了)について届け出ます。  　　　　　　　　　　　＊上記(適用・変更・終了)から該当するものに丸をつける。  　　　　　　　　　　　　在宅→施設：適用　　　施設→施設：変更　　施設→在宅：終了  　　　　　　　　　　　　なお、施設は鈴鹿亀山地区広域連合の地域外の住所地特例施設、  住宅はそれ以外の施設と個人宅等を指します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 届出人氏名 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 本人との関係 | |  |
| 届出人住所 | | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ＊届出者が被保険者本人の場合、届出人住所・電話番号は記載不要 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 被保険者 | 個人番号 | | | |  | | |  | | |  | | |  | | |  | | |  | |  | | |  | | |  | | |  | | |  | | |  | |  | | | |  |
|  | 被保険者証の番号 | | | |  | | | | |  | | |  | | |  | | |  | | |  | | | | |  | | |  | | |  | | |  | | |  | | | |  |
| フリガナ | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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|  | 世帯主 | 個人番号 | | | | |  | | |  | | |  | | |  | | |  | | |  | |  | | |  | | |  | | |  | | |  | |  | |  | | | |  |
|  | 氏名 | |  | | | | | | | | | | | | | | | | | | | | | 世帯主との続柄 | | | | | | | | | | | | | | |  | | | |  |
|  | | | | | | | | | | | | | | | 生年月日 | | 年　　月　　日 | |
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|  | 異動前情報 | 従前の  住所 | | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| ＊異動前住所が施設の場合、以下も記入のこと。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 施設 | 名称 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 退所(居)  年月日 | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 異動後情報 | 現住所 | | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| ＊異動後居住地が施設の場合、以下も記入のこと。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 施設 | 名称 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 入所(居)  年月日 | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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