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| 全民健康保險保險對象投保申報表  表號：承表□C □D □E □F □G □H (本表專供第一至第三類被保險人的投保單位填用) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 收 件 章 | | | | | | | | | | | | | | | 轄區分局 | | | | | | | | | 分局 | | | | | | | | | | | | | | | | | | |
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| 投保單位代號 | | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 民國 | | |  |  | | 年 | | |  | | |  | | | | 月份第 號表 | | | | | | | | | | | |
| 投保者  (打V) | | | 被 保 險 人 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 相 關 眷 屬 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 投保單位填寫  合於投保條件  原因(詳見說明七、八) | | | | | | | | | | | | | | | | | | | | | | | | 核定生效日期(健保局填寫) | | | | | | | | | | | | | | |
| 本  人 | 眷  屬 | | 姓 名 | | | 國民身分證統一編號  (填寫居留證號碼者請於最後一格以英文字母註明性別男-Ｍ、女-Ｆ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 雇主加保請打v | | 投保金額  (元)  (詳見說明四、五) | | | | | | | | | | 姓 名 | | 國民身分證統一編號  (填寫居留證號碼者請於最後一格以英文字母註明性別男-Ｍ、女-Ｆ) | | | | | | | | | | | | | | | | | | | | | | | 稱謂 | | | | 代號 | |
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| 出生年月日(民前出生者請加「-」) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 出生年月日(民前出生者請加「-」) | | | | | | | | | | | | | | | | | | | | | | | 年滿二十歲卑親屬加保原因代號  (詳見說明八) | | | | | | | | | | | | | | | |  | | | | | | |
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| 出生年月日(民前出生者請加「-」) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 出生年月日(民前出生者請加「-」) | | | | | | | | | | | | | | | | | | | | | | | 年滿二十歲卑親屬加保原因代號  (詳見說明八) | | | | | | | | | | | | | | | |  | | | | | | |
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| 投保單位名稱：  ※填表時，請參閱背面說明。  單位圖記  或  印信  通 訊 地 址 ：  電 話：  負 責 人： （印章） 經 辦 人： （印章） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **健**  **保**  **局**  **填**  **用** | | | | | | | 受    理 | | |  | | | | | | | | | | | | 資料鍵錄 | | | |  | | | | | | | | | | | | | 資料校對 | | | | | |  | | | | | | | | | | |
| 歸 檔  批頁號 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |