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| 介護保険料減免取消通知書  第　　　　　号  年　　月　　日 | | | | | | | | | | | | | | | | | | | | | |
|  | 〒　　　　　－  様 | | | | | | 八頭町長　　　　　　　　　　印 | | | | | | | | | | | | | | |
| 年　月　日文書番号で承認しました　　年度分介護保険料の減免については、下記の通り取消しましたので通知します。 | | | | | | | | | | | | | | | | | | | | | |
|  | 被保険者氏名 |  | | | 被保険者番号 | | |  |  |  |  |  |  |  | |  | |  |  |  | |
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|  | 減免取消年月日 | | |  | | | 取消した減免額 | | | | | | | | | |  | | | |  |
| 取消前保険料額 | | |  | | | 取消後保険料額 | | | | | | | | | |  | | | |
| 取消理由 | | |  | | | | | | | | | | | | | | | | |
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| 合計 | |  | | |  | | | | | | | | |  | | | | | |
| 不服の申立  この通知について不服があるときは、この通知書を受け取った日の翌日から起算して３か月以内に鳥取県介護保険審査会に対し審査請求をすることができます。 | | | | | | | | | | | | | | | | | | | | | |