|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **（XX单位）在职职工住院医疗综合互助保障计划名单** | | | | | | |
| **基层工会： （盖 章） 参保期限：2021年6月3日-2022年6月2日** | | | | | | |
| **序 号** | **姓 名** | **性 别** | **身份证号码** | **支付方式** | | **参保人签字** |
| **校工会**  **补助** | **个人现金支付（ ）**  **基层工会支付（ ）** |
| 1 |  |  |  | 50 | 49 |  |
| 2 |  |  |  | 50 | 49 |  |
| 3 |  |  |  | 50 | 49 |  |
| 4 |  |  |  | 50 | 49 |  |
| 5 |  |  |  | 50 | 49 |  |
| 6 |  |  |  | 50 | 49 |  |
| 7 |  |  |  | 50 | 49 |  |
| 8 |  |  |  | 50 | 49 |  |
| 9 |  |  |  | 50 | 49 |  |
| 10 |  |  |  | 50 | 49 |  |
| 11 |  |  |  | 50 | 49 |  |
| 12 |  |  |  | 50 | 49 |  |
| 13 |  |  |  | 50 | 49 |  |
| 14 |  |  |  | 50 | 49 |  |
| 15 |  |  |  | 50 | 49 |  |
| 16 |  |  |  | 50 | 49 |  |
| 17 |  |  |  | 50 | 49 |  |
| 18 |  |  |  | 50 | 49 |  |
| 19 |  |  |  | 50 | 49 |  |
| 20 |  |  |  | 50 | 49 |  |
| 填报人签字： 基层工会主席签字： | | | | | |  |