**附件1：2022年“在职职工重大疾病互助保障计划”参保人员登记表**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 单位： （盖章） | | | | | | | |
| 本期在职职工重大疾病互助保障计划期限为：2022年5月至2023年4月（一年） | | | | | | | |
| **序号** | **姓名** | **性别** | **身份证号** | **学校补助金额（元）** | **个人交费金额（元）** | **份数** | **保费合计** |
| 1 |  |  |  | 30 | 10 | 1 |  |
| 2 |  |  |  | 30 | 10 | 1 |  |
| 3 |  |  |  | 30 | 10 | 1 |  |
| 4 |  |  |  | 30 | 10 | 1 |  |
| 5 |  |  |  | 30 | 10 | 1 |  |
| 6 |  |  |  | 30 | 10 | 1 |  |
| 7 |  |  |  | 30 | 10 | 1 |  |
| 8 |  |  |  | 30 | 10 | 1 |  |
| 9 |  |  |  | 30 | 10 | 1 |  |
| 10 |  |  |  | 30 | 10 | 1 |  |
| 11 |  |  |  | 30 | 10 | 1 |  |
| 12 |  |  |  | 30 | 10 | 1 |  |
| 13 |  |  |  | 30 | 10 | 1 |  |
| 14 |  |  |  | 30 | 10 | 1 |  |
| 15 |  |  |  | 30 | 10 | 1 |  |
| 16 |  |  |  | 30 | 10 | 1 |  |
| 17 |  |  |  | 30 | 10 | 1 |  |
| 18 |  |  |  | 30 | 10 | 1 |  |
| **合计** |  |  |  |  |  |  |  |
| 联系人： 电话： | | | | | | | |