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| 基本养老保险关系转移接续申请表 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓 名 | |  | | 性 别 | |  | | 公民身份号 码 |  | | | | | | | | | | | | | | | | | |
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| 原个人  编 号 | |  | | 户 籍  所在地 | |  | | | | | | | | | | | | | | | | | | | | |
| 原参保 所在地 区名称 | |  | | | | | 原参保地社 保机构行政 区划代码 | |  | | | | | | | | | | | | | | | | | |
| 原参保地社保机构名称 | |  | | | | | 原参保地社保机构联系电话 | |  | | | | | | | | | | | | | | | | | |
| 原参保地社保机构 地址 | |  | | | | | | | 原参保地社保机构邮政编码 | | | | | |  | | | | | | | | | | | |
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| 参保单位（章）: | | |  | |  | | 申请人（签字）： | | | | | | | | | | | | | | | | | | | |
| 联系电话： | | | | |  | | 联系电话： | | | | | | | | | | | | | | | | | | | |
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| （落款中的参保单位和申请人，二选一即可） | | | | | | | | | | | | | | | | | | | | | | | | | | |