

HEALTH INSURANCE DISCLOSURE AFFIDAVIT

COUNTY OF _____

PLAINTIFF / PETITIONER

SS# _____

DOB: _____

STREET RESIDENCE ADDRESS: _____

DEFENDANT / PETITIONER

SS# _____

DOB: _____

STREET RESIDENCE ADDRESS: _____

CASE NUMBER _____

COURT DATE _____

CHILDREN SUBJECT TO SUPPORT ORDER:

NAME: _____ DOB: _____

SS# _____

NAME: _____ DOB: _____

SS# _____

NAME: _____ DOB: _____

SS# _____

NAME: _____ DOB: _____

SS# _____

NAME: _____ DOB: _____

SS# _____

INSTRUCTIONS PART I:

YOU ARE TO DISCLOSE ALL SUCH INFORMATION THAT IS REQUESTED AS IT PERTAINS TO YOU

YOUR NAME _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: () _____

ARE YOU CURRENTLY RECEIVING MEDICAID? YES NO -- MEDICARE? YES NO

DO YOU HAVE FAMILY HEALTH INSURANCE AVAILABLE EITHER THROUGH YOUR EMPLOYER OR ANOTHER GROUP OR ORGANIZATION? YES NO

IS COVERAGE PRESENTLY IN EFFECT? YES NO

WHO IS PRESENTLY COVERED? _____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

INSURER: _____

PHONE: () _____

ADDRESS: _____

POLICY / GROUP # _____

DO YOU PAY A PREMIUM FOR COVERAGE? YES NO

WHAT IS THE PREMIUM FOR FAMILY COVERAGE? \$ _____ PER MONTH YEAR

WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE? \$ _____ PER MONTH YEAR

HEALTH INSURANCE DISCLOSURE AFFIDAVIT

IS A HEALTH INSURANCE CARD AVAILABLE? YES NO

ARE INSURANCE CARDS REQUIRED FOR SERVICES? YES NO

DOES YOUR PLAN COVER HOSPITALIZATION? YES NO

IS THERE A DEDUCTIBLE FOR SERVICES? YES NO

IF YES, WHAT IS THE DEDUCTIBLE? \$ _____ PER VISIT MONTH YEAR

IS THERE A CO-PAYMENT REQUIRED? YES NO

IF YES, WHAT IS THE CO-PAYMENT? \$ _____ PER VISIT MONTH YEAR

DOES YOUR PLAN COVER DOCTOR VISITS? YES NO

IS THERE A DEDUCTIBLE FOR SERVICES? YES NO

IF YES, WHAT IS THE DEDUCTIBLE? \$ _____ PER VISIT MONTH YEAR

IS THERE A CO-PAYMENT REQUIRED? YES NO

IF YES, WHAT IS THE CO-PAYMENT? \$ _____ PER VISIT MONTH YEAR

IS A PRESCRIPTION CARD AVAILABLE? YES NO

IS THERE A CO-PAYMENT REQUIRED? YES NO

IF YES, WHAT IS THE CO-PAYMENT? \$ _____ PER PRESCRIPTION

DOES YOUR PLAN INCLUDE DENTAL COVERAGE? YES NO

DOES YOUR PLAN INCLUDE VISION COVERAGE? YES NO

IS COBRA COVERAGE AVAILABLE? YES NO

(COVERAGE AVAILABLE TO YOU AFTER TERMINATION OF EMPLOYMENT OR MARRIAGE) CHECK ONE

IF YES, WHAT IS THE COST TO YOU? \$ _____ PER MONTH YEAR

INSTRUCTIONS PART II:

YOU ARE TO DISCLOSE ALL SUCH INFORMATION THAT IS REQUESTED AS IT PERTAINS TO THE OTHER PARTY

NAME OF OTHER PARTY _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____ () _____

IS HE/SHE CURRENTLY RECEIVING MEDICAID? YES NO -- MEDICARE? YES NO

DOES HE/SHE HAVE FAMILY HEALTH INSURANCE AVAILABLE EITHER THROUGH HIS/HER EMPLOYER OR ANOTHER GROUP OR ORGANIZATION? YES NO

IS COVERAGE PRESENTLY IN EFFECT? YES NO

WHO IS PRESENTLY COVERED? _____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

HEALTH INSURANCE DISCLOSURE AFFIDAVIT

INSURER: _____

PHONE: (____) _____

ADDRESS: _____

POLICY / GROUP # _____

- DOES HE/SHE PAY A PREMIUM FOR COVERAGE? YES NO
- WHAT IS THE PREMIUM FOR FAMILY COVERAGE? \$ _____ PER MONTH YEAR CHECK ONE
- WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE? \$ _____ PER MONTH YEAR CHECK ONE
- IS HEALTH INSURANCE CARD AVAILABLE? YES NO
- ARE INSURANCE CARDS REQUIRED FOR SERVICES? YES NO
- DOES HIS/HER PLAN COVER HOSPITALIZATION? YES NO
- IS THERE A DEDUCTIBLE FOR SERVICES? YES NO
- IF YES, WHAT IS THE DEDUCTIBLE? \$ _____ PER VISIT MONTH YEAR CHECK ONE
- IS THERE A CO-PAYMENT REQUIRED? YES NO
- IF YES, WHAT IS THE CO-PAYMENT? \$ _____ PER VISIT MONTH YEAR CHECK ONE
- DOES HIS/HER PLAN COVER DOCTOR VISITS? YES NO
- IS THERE A DEDUCTIBLE FOR SERVICES? YES NO
- IF YES, WHAT IS THE DEDUCTIBLE? \$ _____ PER VISIT MONTH YEAR CHECK ONE
- IS THERE A CO-PAYMENT REQUIRED? YES NO
- IF YES, WHAT IS THE CO-PAYMENT? \$ _____ PER VISIT MONTH YEAR CHECK ONE
- DOES HIS/HER PLAN COVER DOCTOR VISITS? YES NO
- IS THERE A DEDUCTIBLE FOR SERVICES? YES NO
- IF YES, WHAT IS THE DEDUCTIBLE? \$ _____ PER VISIT MONTH YEAR CHECK ONE
- IS THERE A CO-PAYMENT REQUIRED? YES NO
- IF YES, WHAT IS THE CO-PAYMENT? \$ _____ PER VISIT MONTH YEAR CHECK ONE
- IS A PRESCRIPTION CARD AVAILABLE? YES NO
- IS THERE A CO-PAYMENT REQUIRED? YES NO
- IF YES, WHAT IS THE CO-PAYMENT? \$ _____ PER PRESCRIPTION
- DOES YOUR PLAN INCLUDE DENTAL COVERAGE? YES NO
- DOES YOUR PLAN INCLUDE VISION COVERAGE? YES NO
- IS COBRA COVERAGE AVAILABLE? YES NO
- (COVERAGE AVAILABLE TO YOU AFTER TERMINATION OF EMPLOYMENT OR MARRIAGE)
- IF YES, WHAT IS THE COST TO HIM/HER? \$ _____ MONTH YEAR CHECK ONE

SIGNATURES MUST BE NOTARIZED

AFFIANT

ATTORNEY FOR AFFIANT

SWORN TO BEFORE ME AND SUBSCRIBED IN MY
PRESENCE, THIS _____ DAY OF _____, 20 _____.

SUPREME COURT NUMBER

NOTARY PUBLIC