

# Health Insurance Availability Form

Name of Party: \_\_\_\_\_

Petitioner: \_\_\_\_\_ Movant: \_\_\_\_\_ Respondent: \_\_\_\_\_

Party's Attorney: J. Darlene Ewing

Beside the name of each child, check all types of health insurance or benefits currently covering that child. You may check more than one source.

## Employer Provided

NAME	DOB	SSN	FATHER'S	MOTHER'S	PRIVATE	OTHER	NONE
------	-----	-----	----------	----------	---------	-------	------

---

---

---

For each insurance source, please list:

- A. Name of Insurance carrier:
- B. Group Policy ID Number
- C. Policyholder Name and ID Number
- D. Name of each child covered:
- E. Cost per month of coverage (Children):\$
- F. Are you paying the premiums for the listed medical benefits?

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name