Print

HEALTH INSURANCE DISCLOSURE AFFIDAVIT

FRANKLIN COUNTY COMMON PLEAS COURT
DIVISION OF DOMESTIC RELATIONS AND JUVENILE BRANCH

John Doe
PLAINTIFF / PETITIONER

SS# _____

DOB: January 1, 1968

ADDRESS: 100 Main Street
Columbus, OH 43201

Jane Doe
DEFENDANT / PETITIONER

SS# _____

DOB: January 1, 1970

ADDRESS: 100 Main Street
Columbus, OH 43201

CASE NUMBER _____

COURT DATE _____

CHILDREN SUBJECT TO SUPPORT ORDER:

NAME: Ann Doe DOB: 01/01/97
SS#: _____

NAME: _____ DOB: _____
SS#: _____

NAME: _____ DOB: _____
SS#: _____

NAME: _____ DOB: _____
SS#: _____

NAME: _____ DOB: _____
SS#: _____

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INSTRUCTIONS PART I:

Please disclose all requested information as it pertains to you

YOUR NAME: John Doe EMPLOYER: WXYZ Services

EMPLOYER ADDRESS: 200 Main Street EMPLOYER PHONE: (100) 100-1000
Columbus, OH 43201

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? John Doe RELATIONSHIP self
Ann Doe RELATIONSHIP daughter
_____ RELATIONSHIP _____
_____ RELATIONSHIP _____
_____ RELATIONSHIP _____

INSURER Blue Cross/Blue Shield PHONE (888) 888-8888

ADDRESS 12345 Sesame Street POLICY/ GROUP # 123456789
Columbus, OH 43201

DO YOU PAY A PREMIUM FOR COVERAGE? ✔ YES _____ NO

WHAT IS THE PREMIUM FOR FAMILY COVERAGE? $ 10.00 PER month/year (circle one)

WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE? $ 10.00 PER month/year (circle one)

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? $ 100.00 per (VISIT) MONTH/YEAR (circle one)

IS THERE A CO-PAYMENT REQUIRED? ✔ YES ____ NO

IF YES, WHAT IS THE CO-PAYMENT? $ 5.00 per (VISIT) MONTH/YEAR (circle one)

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 (circle one)

IS THERE A CO-PAYMENT REQUIRED? ✔ YES ____ NO

IF YES, WHAT IS THE CO-PAYMENT? $ 5.00 per (VISIT) MONTH/YEAR (circle one)

IS A PRESCRIPTION CARD AVAILABLE? ✔ YES ____ NO

IS THERE A CO-PAYMENT REQUIRED? ✔ YES ____ NO

IF YES, WHAT IS THE CO-PAYMENT? $ 5.00 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, AT WHAT COST TO YOU? $____ per MONTH/YEAR (circle one)

INSTRUCTIONS PART II:

Please disclose all requested information as it pertains to the other party

NAME OF OTHER PARTY: Jane Doe EMPLOYER: WXYZ Services

EMPLOYER ADDRESS: 200 Main Street EMPLOYER PHONE: (100) 100-1000

Columbus, OH 43201

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 ____

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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 (circle one)

WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE?$_____ PER month/year (circle one)

IS A 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 (circle one)

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per VISIT/MONTH/YEAR (circle 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 (circle one)

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per VISIT/MONTH/YEAR (circle 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 HIS/HER PLAN INCLUDE DENTAL COVERAGE? _____ YES _____ NO

DOES HIS/HER PLAN INCLUDE VISION COVERAGE? _____YES _____ NO

IS COBRA COVERAGE AVAILABLE? _____ YES _____ NO
(COVERAGE AVAILABLE TO HIM/HER AFTER TERMINATION OF EMPLOYMENT OR MARRIAGE)

IF YES, AT WHAT COST TO HIM/HER? $_____ per MONTH/YEAR (circle one)

SIGNATURES MUST BE NOTARIZED

_____
AFFIANT

_____
ATTORNEY FOR AFFIANT

_____
SUPREME COURT NUMBER

SWORN TO ME AND SUBSCRIBED IN MY PRESENCE,

THIS _____DAY OF _____, 20___

_____
NOTARY PUBLIC

SAMPLE
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