

CAUSE NO.

IN THE MATTER OF THE
MARRIAGE OF

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IN THE DISTRICT COURT

AND

____ JUDICIAL DISTRICT

AND IN THE INTEREST OF

MINOR CHILD(REN).

_____ COUNTY, TEXAS

HEALTH INSURANCE AVAILABILITY

Name of Person carrying coverage: _____ SSN: _____

1. Beside the name of each child, check all types of health insurance or benefits currently covering that child(ren):

	Father's Employer	Mother's Employer	Private	Medicaid	CHIP	Other	None
Child's Name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOB: _____							
SSN: _____							
Child's Name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOB: _____							
SSN: _____							
Child's Name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOB: _____							
SSN: _____							

Father's Employer Mother's Employer Private Medicaid CHIP Other None

Child's Name

DOB: _____

SSN: _____

2. For each insurance source, please list:

- a. Name of Insurance Company _____
- b. Group Policy ID Number _____
- c. Policy holder Name and ID Number _____
- d. Name of Child covered _____
- e. Cost of premium to you (for children): _____

Are you paying the premiums? No Yes

- a. Name of Insurance Company _____
- b. Group Policy ID Number _____
- c. Policy holder Name and ID Number _____
- d. Name of Child covered _____
- e. Cost of premium to you (for children): _____

Are you paying the premiums? No Yes

Signature of person completing form

Printed name: _____