NO. _____

IN THE MATTER OF THE MARRIAGE OF	§	**IN THE DISTRICT COURT**
AND	§	**_____JUDICIAL DISTRICT**
AND IN THE INTEREST OF	§	**_____ COUNTY, TEXAS**

HEALTH INSURANCE AVAILABILITY FORM

NAME OF PARTY: _____ _____PETITIONER_____RESPONDENT

PARTY'S ATTORNEY: Carole Cross

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**	**Medicaid**	**CHIP**	**None**

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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 only): $_____
(To determine coverage for the child(ren), determine total cost for family coverage and subtract from this amount to insure all covered individuals except the children.)
F. Are you paying the premiums for the listed medical benefits? _____Yes _____ No _____

Signature of person completing form

Date _____, 20__

_____

Print Name

_____