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CAUSE NO. \_\_\_\_\_

IN THE MATTER OF (INTEREST OF) \_\_\_\_\_ § IN THE DISTRICT COURT  
\_\_\_\_\_  
§  
AND § OF DALLAS COUNTRY, TEXAS  
\_\_\_\_\_  
§  
\_\_\_\_\_  
§ \_\_\_\_\_ JUDICIAL DISTRICT

**HEALTH INSURANCE AVAILABILITY FORM**

*Attention: This information must be filed with the court BEFORE first hearing.  
See TEX FAM CODE § 154.181(b).*

NAME OF PARTY: \_\_\_\_\_  MOVANT  RESPONDENT

PARTY'S ATTORNEY (IF ANY): \_\_\_\_\_

BESIDE THE NAME OF EACH CHILD, CHECK ALL TYPES OF HEALTH INSURANCE OR HEALTH CARE BENEFITS CURRENTLY COVERING THE CHILD(REN). YOU MAY CHECK MORE THAN ONE SOURCE.

EMPLOYER PROVIDED

NAME	DOB	SSN	FATHER'S	MOTHER'S	PRIVATE	CHIP	OTHER	NONE
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

FOR EACH INSURANCE SOURCE PLEASE LIST THE FOLLOWING INFORMATION:  
(ATTACH ADDITIONAL FORMS FOR EACH SOURCE OF BENEFITS)

A. NAME OF CARRIER \_\_\_\_\_

B. GROUP POLICY ID NUMBER \_\_\_\_\_

C. POLICYHOLDER NAME & ID NUMBER \_\_\_\_\_

D. NAME OF COVERED CHILD \_\_\_\_\_

E. COST/MONTH OF COVERAGE [CHILD{REN) ONLY] \$\_\_\_\_\_

(To determine coverage cost for child(ren), determine total cost for family coverage and subtract from this amount the cost to insure all covered individuals except the children.)

F. ARE YOU CURRENTLY PAYING THE PREMIUMS FOR LISTED MEDICAL BENEFITS?     YES     NO

STATE YOUR NET MONTHLY INCOME FROM YOUR FINANCIAL INFORMATION STATEMENT: \$\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARTY COMPLETING FORM

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME

