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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

