

**IN THE COMMON PLEAS COURT OF MUSKINGUM COUNTY, OHIO
DOMESTIC RELATIONS DIVISION**

Plaintiff/Petitioner 1

vs./and

Defendant/Petitioner 2

Case No. _____

Judge MARIA N. KALIS

Instructions: Check local court rules to determine when this form must be filed. This affidavit is used to disclose health insurance coverage that is available for children of the relationship. It is also used to determine child support. **If more space is needed, add additional pages.**

HEALTH INSURANCE AFFIDAVIT

Affidavit of _____
(Print Name)

		<u>Plaintiff/Petitioner 1</u>		<u>Defendant/Petitioner 2</u>				
Is/are your child(ren) currently enrolled in a government-provided program (i.e. Healthy Start/ Medicaid)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Is/are your child(ren) enrolled in an individual (non-group or COBRA) health insurance plan?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Is/are your child(ren) enrolled in a plan found through the exchange/Affordable HealthCare Marketplace?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Is/are your child(ren) enrolled in a health insurance plan through a group (employer or other organization)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If your child(ren) is/are not enrolled, does/do he/she/they have health insurance available through a group (employer or other organization)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does the available insurance cover primary care services within 30 miles of the children's home?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Under the available insurance, what is the annual premium you pay for family coverage?		\$ _____			\$ _____			
Name of group (employer or organization) that provides health insurance	_____		_____					
Address	_____		_____					
	_____		_____					
Phone Number	_____		_____					

