

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

 Plaintiff/Petitioner 1
 vs./and

 Defendant/Petitioner 2

Case No. _____
 Judge: MARIA N. KALIS
 Magistrate: STEPHANIE L. WILLIAMS

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. It is also used to determine child support. It must be filed if there are minor children of the relationship. **If more space is needed, add additional pages.**

HEALTH INSURANCE AFFIDAVIT
 Affidavit of _____

		<u>Plaintiff/Petitioner 1</u>		<u>Defendant/Petitioner 2</u>				
Is/are your child(ren) currently enrolled in a low-income 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 children 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, do/does 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	_____	_____		_____	_____			

OATH OR AFFIRMATION

(Do not sign until Notary Public is present)

I, (print name) _____, swear or affirm that I have read this Affidavit and, to the best of my knowledge and belief, the facts and information stated in this Affidavit are true, accurate, and complete. I understand that if I do not tell the truth, I may be subject to penalties for perjury.

Your Signature

STATE OF _____)
) **SS**
COUNTY OF _____)

Sworn to or affirmed before me by _____ this _____ day of _____, _____.

Signature of Notary Public

Printed Name of Notary Public

Commission Expiration Date: _____

(Affix seal here)