**(Caption)**
**HEALTH INSURANCE COVERAGE INFORMATION REQUIRED BY THE COURT**

**This form must be completed and returned to the domestic relations section.**

**IF YOU FAIL TO PROVIDE THE INFORMATION REQUESTED, THE COURT MAY FIND THAT YOU ARE IN CONTEMPT OF COURT.**

**Do you provide insurance coverage for the dependents named below? (Check each type of insurance which you provide).**

**Type of Coverage**

| **Full Name SS #** | **Hospital-ization** | **Medical** | **Dental** | **Eye** | **Prescrip-tion** | **Other** |
|---|---|---|---|---|---|---|
| _____ | u | u | u | u | u | u |
| _____ | u | u | u | u | u | u |
| _____ | u | u | u | u | u | u |
| _____ | u | u | u | u | u | u |
| _____ | u | u | u | u | u | u |
| _____ | u | u | u | u | u | u |

Note: Before forwarding the form to the party, the domestic relations section should fill in the names and Social Security numbers of the dependents about whom the information is sought.

**Provide the following information for all types of insurance you maintain, whether or not any of the above-named dependents is covered at this time:**

**Insurance company (provider):**

_____

**Group #:** **Plan #:** **Policy #:**

_____ _____ _____

**Effective coverage date:** **Type of coverage:**

_____ _____

**Employee cost of coverage for dependents:**

_____

**Insurance company (provider):**

_____

**Group #:** **Plan #:** **Policy #:**

_____ _____ _____

**Effective coverage date:** **Type of coverage:**

_____ _____

**Employee cost of coverage for dependents:**

_____

**Insurance company (provider):**

_____

**Group #:** **Plan #:** **Policy #:**

_____ _____ _____

**Effective coverage date:** **Type of coverage:**

_____ _____

**Employee cost of coverage for dependents:**

_____

**If the above-named dependents are not currently covered by insurance, please state the earliest date coverage could be provided.**

_____