

COURT OF COMMON PLEAS
_____ COUNTY, OHIO

Plaintiff/Petitioner 1

v./and

Defendant/Petitioner 2

Case No. _____

Judge _____

Magistrate _____

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 _____
(Print Your Name)

_____ Your Name _____ Spouse's Name

- | | | |
|--|--|--|
| Are your child(ren) currently enrolled in a low-income government-assisted health care program (Healthy Start/Medicaid)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you 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 |
| Are you 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 you are not enrolled, do you 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 child(ren)'s home? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

_____ **Your Name** _____ **Spouse's Name**

Under the available insurance, what would be the annual premium for a plan covering you and the child(ren) of this relationship (not including a spouse)?

\$ _____

\$ _____

Under the available insurance, what would be the annual premium for a plan covering you alone (not including children or spouse)?

\$ _____

\$ _____

If you are enrolled in a health insurance plan through a group (employer or other organization) or individual insurance plan, which of the following people is/are covered:

Yourself?

Yes No

Yes No

Your spouse?

Yes No

Yes No

Minor child(ren) of this relationship?

Yes No

Yes No

Number _____

Number _____

Other individuals?

Yes No

Yes No

Number _____

Number _____

Name of group (employer or organization) that provides health insurance

Address

Phone number

OATH

(Do not sign until notary is present.)

I, (print name) _____, swear or affirm that I have read this document and, to the best of my knowledge and belief, the facts and information stated in this document 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

Sworn before me and signed in my presence this _____ day of _____, _____.

Notary Public

My Commission Expires:
