CAUSE No.________________________________

IN THE MATTER OF (INTEREST OF)	§	IN THE DISTRICT COURT
	§	
___________________________________	§	OF ________________COUNTY, TEXAS
	§	
___________________________________	§	_________JUDICIAL DISTRICT

HEALTH INSURANCE AVAILABILITY FORM

Attention this form must be filed with the court BEFORE first hearing.
See TEX FAM CODE § 154.181(b)

Name of Party: ____ ☐Petitioner ☐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.

NAME	DOB	SSN	Employer Provided FATHER'S	Employer Provided MOTHER'S	PRIVATE	CHIP MEDICAID	OTHER	NONE
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

For each insurance source please list the following information:
(Attach additional forms to each source of benefits)

A. Name of Carrier ____

B. Group Policy ID Number ____

C. Policyholder Name and 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