HEALTH INSURANCE INFORMATION FORM

Case No._____

NAME OF PERSON PROVIDING INSURANCE: _____

PROVIDER OF INSURANCE IS: ☐ Obligor ☐ Obligor's Spouse ☐ Other

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

POLICY EFFECTIVE DATE: _____ ☐ GROUP PLAN ☐ PRIVATE PLAN

POLICY AND/OR GROUP NUMBER: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

* *

NAME OF PERSON PROVIDING INSURANCE: _____

PROVIDER OF INSURANCE IS: ☐ Obligee ☐ Obligee's Spouse ☐ Other

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

POLICY EFFECTIVE DATE: _____ ☐ GROUP PLAN ☐ PRIVATE PLAN

POLICY AND/OR GROUP NUMBER: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

THE FIRST $100 PER CHILD PER YEAR OF MEDICAL EXPENSES WHICH ARE NOT COVERED BY INSURANCE SHALL BE PAID BY _____. ANY ADDITIONAL EXPENSES NOT COVERED BY INSURANCE SHALL BE PAID _____% BY OBLIGOR AND _____% BY OBLIGEE

ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD

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