APPENDIX J

DOMESTIC RELATIONS HEALTH INSURANCE AFFIDAVIT

COURT OF COMMON PLEAS, WOOD COUNTY, OHIO,
DOMESTIC RELATIONS DIVISION

_____ Case No. _____
Plaintiff/Petitioner 1

Judge _____

v./and

Magistrate _____

_____
Defendant/Petitioner 2

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)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you enrolled in an individual (non-group or COBRA) health insurance plan?	☐ Yes ☐ No	☐ Yes ☐ No
Are you enrolled in a health insurance plan through a group (employer or other organization)?	☐ Yes ☐ No	☐ Yes ☐ No
If you are not enrolled, do you have health insurance available through a group (employer or other organization)?	☐ Yes ☐ No	☐ Yes ☐ No
Does the available insurance cover primary care services within 30 miles of the child(ren)'s home?	☐ Yes ☐ No	☐ Yes ☐ 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 Number _____	☐ Yes ☐ No Number _____
Other individuals?	☐ Yes ☐ No Number _____	☐ Yes ☐ No 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:

_____