

NO. \_\_\_\_\_

IN THE MATTER OF  
THE MARRIAGE OF

IN THE DISTRICT COURT

AND

\_\_\_\_\_ JUDICIAL DISTRICT

AND IN THE INTEREST OF

CHILDREN

\_\_\_\_\_ COUNTY, TEXAS

**HEALTH INSURANCE AVAILABILITY FORM**  
**Per TFC 154.181(b)(1)**

Name of party: \_\_\_\_\_  Petitioner  Respondent

Party's attorney: \_\_\_\_\_

Beside the name of each **child**, check all types of health insurance or benefits currently covering that/those child(ren). You may check more than one source.

Name	DOB	SSN	Employer Provided		Private	Medicaid	CHIP	Other	None
			Father's	Mother's					
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each insurance source, please list: (attach additional sheets if more than one source)

- Name of insurance carrier: \_\_\_\_\_
- Group Policy ID Number: \_\_\_\_\_
- Policyholder Name and ID number: \_\_\_\_\_
- Name of child covered: \_\_\_\_\_
- Cost per month of coverage (children): \$ \_\_\_\_\_  
(To determine coverage for the child(ren), determine total cost for family coverage and subtract from this amount to insure all covered individuals except the children.)
- Are you paying the premiums for the listed medical benefits?  Yes  No

\_\_\_\_\_  
Signature of person completing form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name