CAUSE NO. _____

IN THE MATTER OF (INTEREST OF)	§	**IN THE DISTRICT COURT**
	§	
_____	§	_____ **JUDICIAL DISTRICT**
AND	§	
_____	§	_____ **COUNTY, TEXAS**

HEALTH INSURANCE AVAILABILITY FORM

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

NAME OF PARTY: _____ ☐ MOVANT ☐ 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	OTHER	NONE
_____			☐	☐	☐	☐	☐	☐
_____			☐	☐	☐	☐	☐	☐
_____			☐	☐	☐	☐	☐	☐
_____			☐	☐	☐	☐	☐	☐

FOR EACH INSURANCE SOURCE PLEASE LIST THE FOLLOWING INFORMATION :
(ATTACH ADDITIONAL FORMS FOR EACH SOURCE OF BENEFITS)

A. NAME OF CARRIER: _____
B. GROUP POLICY ID NUMBER: _____
C. POLICYHOLDER NAME & 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