HEALTH INSURANCE INFORMATION

FULL NAME *(First, Middle, Last, Suffix)* ☐ CUSTODIAL PARTY ☐ NONCUSTODIAL PARENT

SECTION I: YOUR INSURANCE

Complete this section if your insurance is provided or available through your employer or a private policy maintained by you and not the other parent. Section II is about the insurance provided by the other parent.

HEALTH INSURANCE

Do you currently have Health Insurance coverage? ☐ YES ☐ NO If **YES**, complete the following information.

HEALTH INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: *Street, Apt. or Unit No. (Address where claims are mailed)*

City, State, Zip Code | POLICY NO.

PREMIUM DEDUCTION AMOUNT	CHECK ONE: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY	AMOUNT PAID BY EMPLOYER
AMOUNT PAID BY YOU	CHECK ONE: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY	

NAME(S) OF DEPENDENTS CURRENTLY COVERED BY HEALTH INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

☐ Check here if names & policy numbers of additional dependents covered by Health Insurance are listed on a separate sheet attached.

DENTAL INSURANCE

Do you currently have Dental Insurance coverage? ☐ YES ☐ NO If **YES**, complete the following information.

DENTAL INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: *Street, Apt. or Unit No. (Address where claims are mailed)*

City, State, Zip Code | POLICY NO.

PREMIUM DEDUCTION AMOUNT	CHECK ONE: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY	AMOUNT PAID BY EMPLOYER
AMOUNT PAID BY YOU	CHECK ONE: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY	

NAME(S) OF DEPENDENTS CURRENTLY COVERED BY DENTAL INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

☐ Check here if names & policy numbers of additional dependents covered by Dental Insurance are listed on a separate sheet attached.

VISION INSURANCE

Do you currently have Vision Insurance coverage? ☐ YES ☐ NO If **YES**, complete the following information.

VISION INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: *Street, Apt. or Unit No. (Address where claims are mailed)*

City, State, Zip Code | POLICY NO.

PREMIUM DEDUCTION AMOUNT	CHECK ONE: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY	AMOUNT PAID BY EMPLOYER
AMOUNT PAID BY YOU	CHECK ONE: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY	

NAME(S) OF DEPENDENTS CURRENTLY COVERED BY VISION INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

☐ Check here if names & policy numbers of additional dependents covered by Vision Insurance are listed on a separate sheet attached.

SECTION II: OTHER PARENT'S INSURANCE

HEALTH INSURANCE

Does the other parent currently provide Health Insurance coverage for the children or you? ☐ YES ☐ NO If **YES**, complete the following information.

HEALTH INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: *Street, Apt. or Unit No. (Address where claims are mailed)*

City, State, Zip Code

DENTAL INSURANCE

Does the other parent currently provide Dental Insurance coverage for the children or you? ☐ YES ☐ NO If **YES**, complete the following information.

DENTAL INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: *Street, Apt. or Unit No. (Address where claims are mailed)*

City, State, Zip Code

VISION INSURANCE

Does the other parent currently provide Vision Insurance coverage for the children or you? ☐ YES ☐ NO If **YES**, complete the following information.

VISION INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: *Street, Apt. or Unit No. (Address where claims are mailed)*

City, State, Zip Code