

**COURT OF COMMON PLEAS**  
\_\_\_\_\_ COUNTY, OHIO

\_\_\_\_\_  
Plaintiff/Petitioner 1

v./and

\_\_\_\_\_  
Defendant/Petitioner 2

Case No. \_\_\_\_\_

Judge \_\_\_\_\_

Magistrate \_\_\_\_\_

**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

Yes  No

Number \_\_\_\_\_

Number \_\_\_\_\_

Other individuals?

Yes  No

Yes  No

Number \_\_\_\_\_

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:  
\_\_\_\_\_