

STATEMENT OF HEALTH INSURANCE AVAILABILITY

Cause No: _____

Caption: _____

This statement is made by _____, in accordance with section 154.181 of the Texas Family Code.

1. Children

The following child(ren) are subject of this suit:

Name	Date of Birth	Social Security Number
		last four digits: _____
		last four digits: _____
		last four digits: _____
		last four digits: _____
		last four digits: _____
		last four digits: _____

2. Health Insurance Availability (check the applicable column)

Name of Child	Father's employer provides health ins.	Mother's employer provides health ins.	Private health ins. provided through source other than parent's employer	Medicaid	CHIP	None

3. *Further information about private insurance source (if applicable)*

A. Name of insurance carrier: _____

B. Group Policy ID No.:

C. Policy holder Name & ID No.: _____

D. Name of each child covered: _____

E. Cost per month of coverage for child(ren): _____

(To determine coverage for the child(ren), determine the total cost for family coverage and subtract from this amount to insure all covered individuals except the children).

F. _____ is responsible for paying the premium.

G. Insurance is provided through employment of mother/employment of father/other source (circle one). If other source, please state who obtained the insurance:

4. *Further information about public insurance sources (if applicable)*

The premium for child(ren) covered by CHIP is: \$_____.

_____ is responsible for paying the premium.

5. *Further information about reasons why health insurance is not currently provided (if applicable)*

A. _____ (mother) does/does not (circle one) have access to private health insurance. _____ (father) does/does not (circle one) have access to private health insurance.

B. _____ (name of party) has applied for coverage under _____ (name of insurance carrier/program). The status of the application is:

_____.

Date: _____

Signature

Printed Name