

**COURT OF COMMON PLEAS  
DOMESTIC RELATIONS DIVISION  
CUYAHOGA 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.**

**STATEMENT OF HEALTH INSURANCE**

This statement is made by \_\_\_\_\_  
(Print Your Name)

\_\_\_\_\_ **Your Name** \_\_\_\_\_ **Other Parent**

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**                      \_\_\_\_\_ **Other Parent**

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

\_\_\_\_\_

\_\_\_\_\_

**STATEMENT OF TRUTH**

The information above is true, complete, and accurate to the best of my knowledge. I understand that knowingly providing false information in this document may result in a contempt of court finding against me which could result in a jail sentence and fine, or criminal penalties under R.C. 2921.13.

\_\_\_\_\_  
Your Signature