

Health Insurance Disclosure Form

Tuscola County FOC

Your Name: _____

Docket Number: _____

Current Address: _____

Phone Number: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Do you or your current spouse carry insurance on your child(ren) (This includes private, employer or state aid insurance.) Yes___ or No___?

IF YOU ANSWERED YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Who carries the insurance (check the appropriate box): You _____ or Your Spouse_____
2. Name of Insurance Company: _____
3. Address of Insurance Company: _____
4. Group Number: _____
5. Policy Number: _____
6. Effective Date: _____
7. Types of coverage your insurance provides (check all that apply):
 Medical___ Dental___ Vision___ Prescription___ Hospitalization___
8. List the names of **all** children that are covered by this policy:

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

PLEASE ATTACH PHOTOCOPY (Front & Back) OF YOUR INSURANCE

Date: _____ **Signature:** _____