Tuscola County Friend of the Court: 440 N. State Street, Caro, MI 48723 PH: 989-673-4848 FAX: 989-673-4898

Health Insurance Disclosure Form

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 SELECT ONE OF THE FOLLOWING PROVIDERS:

___Private ___Employer ___State Aid Insurance

CONTINUE ANSWERING THE FOLLOWING QUESTIONS:

1. Who carries the insurance: 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

PLEASE ATTACH PHOTOCOPY (Front & Back) OF YOUR INSURANCE CARD

Date: _____ **Signature:** _____