IN THE COURT OF COMMON PLEAS
JUVENILE DIVISION
WAYNE COUNTY, OHIO

PRIVATE HEALTH INSURANCE COVERAGE
INFORMATION SHEET

In re: _____ Case No. _____
[Child's Name]
Name of Father:_____
Name of Mother:_____

___ Neither parent has private health insurance coverage available for the child.

OR

___ Mother ___ Father hereby provides the following information pursuant to the requirements of §3119.30 R.C. regarding the availability of private health insurance coverage for the child subject to the Medical Support Order.

MOTHER

Name of employer/group/individual	_____
Name of insurance company	_____
Claims address of insurance company	_____
Customer service telephone number	_____
Group number	_____
Identification/Subscriber number	_____

FATHER

Name of employer/group/individual	_____
Name of insurance company	_____
Claims address of insurance company	_____
Customer service telephone number	_____
Group number	_____
Identification/Subscriber number	_____

The following child subject to the Medical Support Order is designated as a covered dependent under the private health insurance policy, contract or plan:

Child's name: _____ Date of Birth_____

The following individual shall be reimbursed for covered out-of-pocket medical, optical, hospital, dental, or prescription expenses paid for the above named child:

Name of party:	_____OBLIGEE_____
Address	_____
	_____
Telephone number	_____

Prepared by:
Counsel:_____ Pro se:_____
(For Mother / Father)
CSEA: _____ Other:_____

Information Has Been Reviewed and Agreed To:

_____ _____
Mother Date

_____ _____
Father Date