

**DELAWARE COUNTY COMMON PLEAS COURT  
DOMESTIC RELATIONS DIVISION**

**DELAWARE COUNTY COURT FORM 6 – HEALTH INSURANCE DISCLOSURE AFFDIAVIT**

\_\_\_\_\_  
**PLAINTIFF / PETITIONER**  
SS# \_\_\_\_\_  
DOB: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

CASE NUMBER \_\_\_\_\_

COURT DATE \_\_\_\_\_

**CHILDREN SUBJECT TO SUPPORT ORDER:**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

\_\_\_\_\_  
**DEFENDANT / PETITIONER**  
SS# \_\_\_\_\_  
DOB: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

**INSTRUCTIONS PART I:**

Please disclose all requested information as it pertains to you

YOUR NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

ARE YOU CURRENTLY RECEIVING MEDICAID? \_\_\_ YES \_\_\_ NO / MEDICARE? \_\_\_ YES \_\_\_ NO

DO YOU HAVE FAMILY HEALTH INSURANCE AVAILABLE EITHER THROUGH YOUR EMPLOYER OR ANOTHER GROUP OR ORGANIZATION? \_\_\_ YES \_\_\_ NO

IS COVERAGE PRESENTLY IN EFFECT? \_\_\_ YES \_\_\_ NO

WHO IS PRESENTLY COVERED? \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

INSURER \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ POLICY/ GROUP # \_\_\_\_\_

\_\_\_\_\_

DO YOU PAY A PREMIUM FOR COVERAGE? \_\_\_\_\_ YES \_\_\_\_\_ NO

WHAT IS THE PREMIUM FOR FAMILY COVERAGE? \$ \_\_\_\_\_ PER month/year (circle one) WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE? \$ \_\_\_\_\_ PER month/year (circle one)

**IS A HEALTH INSURANCE CARD AVAILABLE?** \_\_\_\_\_ YES \_\_\_\_\_ NO

ARE INSURANCE CARDS REQUIRED FOR SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO

**DOES YOUR PLAN COVER HOSPITALIZATION?** \_\_\_\_\_ YES \_\_\_\_\_ NO

IS THERE A DEDUCTIBLE FOR SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHAT IS THE DEDUCTIBLE? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)

IS THERE A CO-PAYMENT REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHAT IS THE CO-PAYMENT? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)

**DOES YOUR PLAN COVER DOCTOR VISITS?** \_\_\_\_\_ YES \_\_\_\_\_ NO

IS THERE A DEDUCTIBLE FOR SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHAT IS THE DEDUCTIBLE? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)

IS THERE A CO-PAYMENT REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHAT IS THE CO-PAYMENT? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)

**IS A PRESCRIPTION CARD AVAILABLE?** \_\_\_\_\_ YES \_\_\_\_\_ NO

IS THERE A CO-PAYMENT REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHAT IS THE CO-PAYMENT? \$ \_\_\_\_\_ per PRESCRIPTION

DOES YOUR PLAN INCLUDE DENTAL COVERAGE? \_\_\_\_\_ YES \_\_\_\_\_ NO

DOES YOUR PLAN INCLUDE VISION COVERAGE? \_\_\_\_\_ YES \_\_\_\_\_ NO

IS COBRA COVERAGE AVAILABLE? \_\_\_\_\_ YES \_\_\_\_\_ NO  
(COVERAGE AVAILABLE TO YOU AFTER TERMINATION OF EMPLOYMENT OR MARRIAGE)

IF YES, AT WHAT COST TO YOU? \$ \_\_\_\_\_ per MONTH/YEAR (circle one)

**INSTRUCTIONS PART II:**

Please disclose all requested information as it pertains to the other party

NAME OF OTHER PARTY: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

IS HE/SHE CURRENTLY RECEIVING MEDICAID? \_\_\_ YES \_\_\_ NO / MEDICARE? \_\_\_ YES \_\_\_ NO

DOES HE/SHE HAVE FAMILY HEALTH INSURANCE AVAILABLE EITHER THROUGH HIS/HER EMPLOYER OR ANOTHER GROUP OR ORGANIZATION? \_\_\_ YES \_\_\_ NO

IS COVERAGE PRESENTLY IN EFFECT? \_\_\_ YES \_\_\_ NO

WHO IS PRESENTLY COVERED? \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
\_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
\_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
\_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
\_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_

INSURER \_\_\_\_\_ PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ POLICY/ GROUP # \_\_\_\_\_  
\_\_\_\_\_

DOES HE/SHE PAY A PREMIUM FOR COVERAGE? \_\_\_\_\_ YES \_\_\_\_\_ NO  
WHAT IS THE PREMIUM FOR FAMILY COVERAGE? \$ \_\_\_\_\_ PER month/year (circle one)  
WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE? \$ \_\_\_\_\_ PER month/year (circle one)

**IS A HEALTH INSURANCE CARD AVAILABLE?** \_\_\_\_\_ YES \_\_\_\_\_ NO  
ARE INSURANCE CARDS REQUIRED FOR SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO

**DOES HIS/HER PLAN COVER HOSPITALIZATION?** \_\_\_\_\_ YES \_\_\_\_\_ NO  
IS THERE A DEDUCTIBLE FOR SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, WHAT IS THE DEDUCTIBLE? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)  
IS THERE A CO-PAYMENT REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, WHAT IS THE CO-PAYMENT? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)

**DOES HIS/HER PLAN COVER DOCTOR VISITS?** \_\_\_\_\_ YES \_\_\_\_\_ NO  
IS THERE A DEDUCTIBLE FOR SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, WHAT IS THE DEDUCTIBLE? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)  
IS THERE A CO-PAYMENT REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, WHAT IS THE CO-PAYMENT? \$ \_\_\_\_\_ per VISIT/MONTH/YEAR (circle one)

**IS A PRESCRIPTION CARD AVAILABLE?** \_\_\_\_\_ YES \_\_\_\_\_ NO  
IS THERE A CO-PAYMENT REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, WHAT IS THE CO-PAYMENT? \$ \_\_\_\_\_ per PRESCRIPTION

**DOES HIS/HER PLAN INCLUDE DENTAL COVERAGE?** \_\_\_\_\_ YES \_\_\_\_\_ NO  
**DOES HIS/HER PLAN INCLUDE VISION COVERAGE?** \_\_\_\_\_ YES \_\_\_\_\_ NO

**IS COBRA COVERAGE AVAILABLE?** \_\_\_\_\_ YES \_\_\_\_\_ NO  
(COVERAGE AVAILABLE TO HIM/HER AFTER TERMINATION OF EMPLOYMENT OR MARRIAGE)  
IF YES, AT WHAT COST TO HIM/HER? \$ \_\_\_\_\_ per MONTH/YEAR (circle one)

**SIGNATURES MUST BE NOTARIZED**

\_\_\_\_\_  
AFFIANT

\_\_\_\_\_  
ATTORNEY FOR AFFIANT

\_\_\_\_\_  
SUPREME COURT NUMBER

SWORN TO ME AND SUBSCRIBED IN MY PRESENCE, THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC