

<b>STATE OF ILLINOIS, CIRCUIT COURT</b>  _____ <b>COUNTY</b>	<b>Additional Health Insurance (FINANCIAL AFFIDAVIT)</b>  <input type="checkbox"/> <b>Pre-Judgment</b> <input type="checkbox"/> <b>Post-Judgment</b>	<i>For Court Use Only</i>
<b>Instructions ▼</b> Enter above the county name where the case was filed.  Enter name of the Petitioner, the Respondent, and the case number as listed in the initial Petition or Complaint.  Enter the Case Number given by the Circuit Clerk.	<div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <b>Petitioner</b> <i>(First, middle, last name)</i> </div> <div style="margin-bottom: 10px;">v.</div> <div style="border-bottom: 1px solid black;"> <b>Respondent</b> <i>(First, middle, last name)</i> </div>	<div style="border-bottom: 1px solid black; margin-top: 20px;"> <b>Case Number</b> </div>

**IMPORTANT:** If you intentionally or recklessly enter inaccurate or misleading information on this form, you may face significant penalties and sanctions, including costs and attorney's fees.

Fill out this form only if you have additional **Health Insurance** carriers. If you fill out this form, attach it to your *Financial Affidavit*.

In **13**, enter information about the primary health insurance you have for yourself and your family.

**13. Health Insurance**

I have health insurance: ☐ Yes ☐ No

Name of insurance company: \_\_\_\_\_

Type of insurance: ☐ Medical ☐ Dental ☐ Orthodontic (braces) ☐ Vision

Type of Policy: ☐ HMO ☐ PPO ☐ Other

Provided through: ☐ Employer ☐ Private Policy ☐ Other Group Policy ☐ Medicaid/All Kids

Total number of people covered by this policy: \_\_\_\_\_

The insurance covers: ☐ Me ☐ My spouse/partner ☐ children of this relationship  
☐ children of this relationship and other children  
 (if you check this box, list the number of the other children covered and their ages):  
 \_\_\_\_\_

Total monthly cost for this insurance is \$\_\_\_\_\_

This cost is paid by: ☐ Me ☐ My spouse/partner ☐ Other: \_\_\_\_\_

Monthly cost for this insurance for covering children: \$\_\_\_\_\_

Monthly cost for this insurance for covering children of this relationship (if known): \$\_\_\_\_\_

Yearly Deductible (amount you pay before your insurance starts to pay):  
 Per individual \$\_\_\_\_\_ Per family \$\_\_\_\_\_

Coinsurance (percentage of costs you pay, e.g. 20%): \_\_\_\_\_

Copayment (a flat amount you pay per service, e.g. \$20): \$ \_\_\_\_\_

☐ I have more than two health insurance policies and so I have attached  
 \_\_\_\_\_ *Additional Health Insurance forms*  
*Number*

If you are attaching more than one additional health insurance forms, list the number of forms you are attaching.