

IN THE COMMON PLEAS COURT OF \_\_\_\_\_ COUNTY, OHIO

DIVISION OF \_\_\_\_\_

\_\_\_\_\_  
Plaintiff / Petitioner

V.

\_\_\_\_\_  
Defendant / Petitioner

Case No. \_\_\_\_\_

CSEA Account No. \_\_\_\_\_

Family File No. \_\_\_\_\_

JUDGE \_\_\_\_\_

MAGISTRATE \_\_\_\_\_

### Health Insurance Disclosure Affidavit (HIDA)

INSTRUCTIONS: This affidavit must be filed according to local rules of court. You are required to disclose all requested information. You may need to consult your employer and insurer to complete this form, There is a continuing duty to update the information contained in this form. If more space is needed, attach additional page(s). Please type or print legibly.

Husband / Father / Other

\_\_\_\_\_  
DOB                      SS#

\_\_\_\_\_  
Street Residence Address

\_\_\_\_\_  
\_\_\_\_\_

Wife / Mother / Other

\_\_\_\_\_  
DOB                      SS#

\_\_\_\_\_  
Street Residence Address

\_\_\_\_\_  
\_\_\_\_\_

Children Subject To Support Order

Name

\_\_\_\_\_  
DOB                      SS#

\_\_\_\_\_  
Name

\_\_\_\_\_  
DOB                      SS#

\_\_\_\_\_  
Name

\_\_\_\_\_  
DOB                      SS#

\_\_\_\_\_  
Name

\_\_\_\_\_  
DOB                      SS#

You are to disclose all requested information in the column for you and in the column for the other party.

**Part I  
Husband / Father / Other**

**Part II  
Wife / Mother / Other**

Name

Name

Employer

Employer

Employer Address

Employer Address

Employer Phone

Employer Phone

Is Medicaid coverage available?  Yes  No

Is Medicaid coverage available?  Yes  No

Is Medicare coverage available?  Yes  No

Is Medicare coverage available?  Yes  No

Is family Health insurance available either through the employer or another group or organization?  Yes  No

Is family Health insurance available either through the employer or another group or organization?  Yes  No

If not, is Private insurance available?  Yes  No

If not, is Private insurance available?  Yes  No

Is coverage presently in effect?  Yes  No

Is coverage presently in effect?  Yes  No

Who is presently covered?

Name Relationship

Name Relationship

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Insurer / Plan Name Phone

Insurer / Plan Name Phone

Address

Address

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Policy / Group #

Policy / Group #

Other Policy / Group # (if another policy is available)

Other Policy / Group # (if another policy is available)

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You are to disclose all requested information in the column for you and in the column for the other party.

**Part I (Continued)**  
**Husband / Father / Other**

Is there a cost for coverage?  Yes  No

**Special Instruction** - The court requires both the family cost and the Individual cost information.

What is the annual cost for Family coverage?  
\$

What is the annual cost for individual coverage?  
\$

Is a Health insurance card available?  Yes  No

Are insurance cards required for services?  Yes  No

Does the plan cover Hospitalization?  Yes  No

Is there a deductible for services?  Yes  No

If yes, what is the deductible?  
\$  Check One: Per  Visit  Mo  Yr

Is there a co-payment required?  Yes  No

If yes, what is the co-payment?  
\$  Check One: Per  Visit  Mo  Yr

Does the plan cover doctor visits?  Yes  No

Is there a deductible for services?  Yes  No

If yes, what is the deductible?  
\$  Check One: Per  Visit  Mo  Yr

Is there a co-payment required?  Yes  No

If yes, what is the co-payment?  
\$  Check One: Per  Visit  Mo  Yr

**Part II (Continued)**  
**Wife / Mother / Other**

Is there a cost for coverage?  Yes  No

**Special Instruction** - The court requires both the family cost and the Individual cost information.

What is the annual cost for Family coverage?  
\$

What is the annual cost for individual coverage?  
\$

Is a Health insurance card available?  Yes  No

Are insurance cards required for services?  Yes  No

Does the plan cover Hospitalization?  Yes  No

Is there a deductible for services?  Yes  No

If yes, what is the deductible?  
\$  Check One: Per  Visit  Mo  Yr

Is there a co-payment required?  Yes  No

If yes, what is the co-payment?  
\$  Check One: Per  Visit  Mo  Yr

Does the plan cover doctor visits?  Yes  No

Is there a deductible for services?  Yes  No

If yes, what is the deductible?  
\$  Check One: Per  Visit  Mo  Yr

Is there a co-payment required?  Yes  No

If yes, what is the co-payment?  
\$  Check One: Per  Visit  Mo  Yr

You are to disclose all requested information in the column for you and in the column for the other party

Part I (Continued)  
Husband / Father/ Other

Part II (Continued)  
Wife / Mother / Other

Is a Prescription card available?  Yes  No

Is a Prescription card available?  Yes  No

Is there a co-payment required?  Yes  No

Is there a co-payment required?  Yes  No

If yes, what is the co-payment?

If yes, what is the co-payment?

\$  Per Prescription

\$  Per Prescription

Is Dental coverage available?  Yes  No

Is Dental Coverage available?  Yes  No

Insurer / Plan Name Phone

Insurer / Plan Name Phone

Address

Address

Policy / Group #

Policy / Group #

Is there a cost for Dental coverage?  Yes  No

Is there a cost for Dental coverage?  Yes  No

**Special Instruction** - The court requires both the family cost and the individual cost information.

What is the annual cost for Family Dental coverage?

\$

What is the annual cost for individual Dental coverage?

\$

**Special Instruction** - The court requires both the family cost and the individual cost information.

What is the annual cost for Family Dental coverage?

\$

What is the annual cost for Individual Dental coverage?

\$

Is a Dental insurance card available?  Yes  No

Is a Dental insurance card available?  Yes  No

Are Dental insurance cards required For services?  Yes  No

Are Dental insurance cards required For services?  Yes  No

Is Vision coverage available?  Yes  No

Is Vision coverage available?  Yes  No

Insurer / Plan Name Phone

Insurer / Plan Name Phone

Address

Address

Policy / Group #

Policy / Group #

You are to disclose all requested information in the column for you and in the column for the other party.

**Part I (Continued)**  
**Husband / Father / Other**

**Part II (Continued)**  
**Wife / Mother / Other**

Is there a cost for Vision coverage?  Yes  No

Is there a cost for Vision coverage?  Yes  No

**Special Instruction** - The court requires both the family cost and the individual cost information.

What is the annual cost for Family Vision coverage?

\$

What is the annual cost for Individual Vision coverage?

\$

**Special Instruction** - The court requires both the family cost and the individual cost information.

What is the annual cost for Family Vision coverage?

\$

What is the annual cost for Individual Vision coverage?

\$

Is Vision insurance card available?  Yes  No

Is Vision insurance card available?  Yes  No

Are Vision insurance cards required for services?  Yes  No

Are Vision insurance cards required for services?  Yes  No

Is COBRA insurance available?  
(A continuation of present insurance coverage after termination of employment or marriage)

If yes, at what cost?

\$

Check One:

Per  Mo  Yr

Is COBRA insurance available?  
(A continuation of present insurance coverage after termination of employment or marriage)

If yes, at what cost?

\$

Check One:

Per  Mo  Yr

Instructions: In a divorce or post decree action, only the party filing the HIDA is required to sign the oath. In a dissolution action, both parties must sign the oath.

**OATH OF AFFIANT(S) - SIGNATURE(S) MUST BE NOTARIZED**

I hereby swear or affirm that the information set forth in this health insurance disclosure affidavit above is true, complete and accurate. I understand that falsification of this document may result in a contempt of court finding against me which could result in a jail sentence and fine, and that falsification of this document may also subject me to criminal penalties for perjury (O.R.C. 2921.11).

\_\_\_\_\_  
AFFIANT - Husband / Father / Other

\_\_\_\_\_  
AFFIANT - Wife / Mother / Other

Sworn to and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Notary Public