MEDICAL SUPPORT AFFIDAVIT

INSTRUCTIONS: THIS AFFIDAVIT IS TO ASSIST YOU IN PRESENTING INFORMATION ABOUT HEALTH INSURANCE COVERAGE THAT IS OR MAY BE AVAILABLE FOR YOUR CHILDREN. PLEASE COMPLETE THIS FORM, SIGN IT IN THE PRESENCE OF A NOTARY PUBLIC, AND RETURN IT WITHIN 10 DAYS TO THE ND CHILD SUPPORT DIVISION AT THE FOLLOWING ADDRESS: CENTURY CENTER BUILDING, PO BOX 7190, BISMARCK ND 58507 7190. FAILURE TO COMPLETE AND RETURN THIS FORM MAY RESULT IN FURTHER ACTIONS BEING TAKEN BY OUR OFFICE.

I. PERSONAL INFORMATION:

NAME (FIRST, MIDDLE, LAST, SUFFIX): _____
SOCIAL SECURITY NUMBER: _____
ADDRESS: _____
_____
HOME TELEPHONE NUMBER: _____
CELLULAR TELEPHONE NUMBER: _____
EMAIL ADDRESS: _____
DATE OF BIRTH: _____
OCCUPATION: _____
EMPLOYER NAME AND ADDRESS: _____
_____
_____
EMPLOYER TELEPHONE NUMBER: _____
LENGTH OF TIME WITH EMPLOYER: _____YEARS _____ MONTHS

II. IS THERE A COURT ORDER THAT REQUIRES YOU TO PROVIDE HEALTH INSURANCE COVERAGE FOR YOUR CHILDREN?

- ☐ YES
- ☐ NO

III. HAVE YOU ENROLLED YOUR CHILDREN IN HEALTH INSURANCE COVERAGE?

- ☐ YES; COMPLETE SECTION A, BUT NOT SECTION B
- ☐ NO; COMPLETE SECTION B, BUT NOT SECTION A

SECTION A

1. HAVE YOU ENROLLED YOUR CHILDREN IN HEALTH INSURANCE COVERAGE THROUGH (CHECK ONE):

- ☐ YOUR EMPLOYER
- ☐ YOUR UNION
- ☐ OTHER GROUP HEALTH INSURANCE

2. NAME AND ADDRESS OF INSURANCE COMPANY: _____
_____
_____

3. POLICYHOLDER NAME: _____

4. TYPE(S) OF COVERAGE (CHECK ALL THAT APPLY):

- ☐ BASIC HOSPITAL
- ☐ MEDICAL/SURGICAL
- ☐ MAJOR MEDICAL
- ☐ NURSING HOME
- ☐ DENTAL
- ☐ VISION
- ☐ INDEMNITY
- ☐ CHAMPUS/DEERS/TRICARE

5. IS THERE A COST FOR INCLUDING YOUR CHILDREN ON YOUR HEALTH INSURANCE POLICY?

- ☐ YES; COST FOR A SINGLE PLAN IS $ _____ PER MONTH.
  COST FOR A SINGLE + DEPENDENT PLAN IS $ _____ PER MONTH.
  COST FOR A FAMILY PLAN IS $ _____ PER MONTH.
  COST FOR A CHILD OR CHILDREN ONLY IS $ _____ PER MONTH.
- ☐ NO

6. TYPE OF POLICY (CHECK ONE):

- ☐ GROUP
- ☐ INDIVIDUAL

7. NAME OF EMPLOYER (IF DIFFERENT THAN IN PART I), UNION, OR OTHER GROUP THROUGH WHICH YOUR CHILDREN ARE ENROLLED: _____

8. ADDRESS OF EMPLOYER (IF DIFFERENT THAN IN PART I), UNION, OR OTHER GROUP THROUGH WHICH YOUR CHILDREN ARE ENROLLED: _____

_____

9. GROUP NAME AND NUMBER: _____

10. POLICY NUMBER: _____

11. CLAIMS ARE SUBMITTED (CHECK ONE):

- ☐ BY EMPLOYER
- ☐ TO INSURANCE COMPANY

12. COVERAGE START DATE: _____

13. PERSONS COVERED BY HEALTH INSURANCE POLICY. INCLUDE INDIVIDUALS' NAMES, DATES OF BIRTH, AND RELATIONSHIP TO YOU:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION B

1. REASON(S) FOR NOT ENROLLING YOUR CHILDREN IN HEALTH INSURANCE COVERAGE (CHECK ALL THAT APPLY):

☐ I AM UNEMPLOYED AND DO NOT HAVE GROUP HEALTH INSURANCE AVAILABLE TO ME.

☐ I AM SELF-EMPLOYED AND DO NOT HAVE GROUP HEALTH INSURANCE AVAILABLE TO ME.

☐ MY EMPLOYER DOES NOT OFFER AN INSURANCE PLAN.

☐ MY EMPLOYER OFFERS AN INSURANCE PLAN BUT I AM NOT ELIGIBLE FOR COVERAGE YET. I WILL BE ELIGIBLE FOR COVERAGE ON _____.

☐ MY CHILDREN WOULD NOT GAIN ADDITIONAL BENEFITS IF ENROLLED IN MY INSURANCE PLAN BECAUSE: _____

_____

_____

_____

☐ SOMEONE ELSE IS PROVIDING COVERAGE FOR MY CHILDREN.

NAME OF PERSON PROVIDING COVERAGE: _____

RELATIONSHIP OF THAT PERSON TO CHILDREN: _____

☐ OTHER _____

_____

_____

2. EVEN THOUGH YOU HAVE NOT ENROLLED YOUR CHILDREN IN HEALTH INSURANCE COVERAGE, IF HEALTH INSURANCE IS OR WILL BE AVAILABLE, PLEASE PROVIDE THE FOLLOWING COST INFORMATION:

☐ THERE IS/WILL BE A COST FOR INCLUDING MY CHILDREN IN AN AVAILABLE HEALTH INSURANCE PLAN.

COST FOR A SINGLE PLAN IS/WILL BE $ _____ PER MONTH.

COST FOR A SINGLE + DEPENDENT PLAN IS/WILL BE $ _____ PER MONTH.

COST FOR A FAMILY PLAN IS/WILL BE $ _____ PER MONTH.

COST FOR A CHILD OR CHILDREN ONLY IS/WILL BE $ _____ PER MONTH.

☐ NONAPPLICABLE; THERE IS/WILL BE NO COST FOR INCLUDING MY CHILDREN IN AN AVAILABLE HEALTH INSURANCE PLAN.

☐ NONAPPLICABLE; THERE IS NO AVAILABLE HEALTH INSURANCE PLAN.

IV. STATEMENT AND SIGNATURE:

I, _____, BEING FIRST DULY SWORN, DO DEPOSE AND STATE THAT THE INFORMATION GIVEN ABOVE IS TRUE TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF. I FURTHER AUTHORIZE THE USE AND RELEASE OF THIS AFFIDAVIT AND THE INFORMATION CONTAINED HEREIN BY THE CHILD SUPPORT PROGRAM FOR THE PURPOSE OF ESTABLISHING OR ENFORCING MEDICAL SUPPORT FOR MY CHILDREN.

SIGNATURE: _____

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

_____

NOTARY PUBLIC

_____ COUNTY, NORTH DAKOTA