This form is approved by the Illinois Supreme Court and is required to be used in all Illinois Circuit Courts.

STATE OF ILLINOIS, CIRCUIT COURT COUNTY	**Additional Health Insurance** (FINANCIAL AFFIDAVIT) ☐ **Pre-Judgment** ☐ **Post-Judgment**	*For Court Use Only*

Instructions ▼	
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.	**Petitioner** *(First, middle, last name)* v. **Respondent** *(First, middle, last name)*
Enter the Case Number given by the Circuit Clerk.	**Case Number**

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): $ _____

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

☐ I have more than two health insurance policies and so I have attached

_____ *Additional Health Insurance* forms

Number