Health Insurance Information Form

Name: _____ Case No. _____

Employer: _____

Annual Wages: _____

List of insurance plans for which you are eligible. List names and addresses.

_____

_____

_____

_____

_____

Does your insurance provide primary care within 30 miles of home? _____

Do the children need public transportation to get to primary care? _____

Cost of individual coverage: _____ Cost of family coverage: _____

Total number of dependents to be covered: _____

Number of children in this case to be covered: _____