connecting hearts adoption services

Health Insurance Verification

This is to verify that I/we have health insurance through _____
and that any adopted child is covered under this policy from his/her date of birth.

Attached is a copy of our health insurance card.

_____ _____
Adoptive Mother Date

_____ _____
Adoptive Father Date

Guardianship Appointee

Do you have a legal will? Yes _____ No _____

If so, date of will _____

In the event of the deaths or incapacitation of (Name of Parents) _____,

I/ We have instructed the following person(s) to assume guardianship of our child(ren):

NAME:_____

Relationship _____

ADDRESS:_____

_____

PHONE #: _____

Profession of Male Guardian:_____ Age_____

Profession of Female Guardian:_____ Age_____

Signed:_____ Date_____
Adoptive Parent

Signed:_____ Date_____
Adoptive Parent