



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.

Applicant Date

Applicant 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 Guardian: _____ Age _____

Profession of Guardian: _____ Age _____

Signed: _____ Date _____
Applicant

Signed: _____ Date _____
Applicant