

**IN THE COURT OF COMMON PLEAS OF MERCER COUNTY, OHIO
DOMESTIC RELATIONS DIVISION
MEDICAL HEALTHCARE INFORMATION
[DR 8]**

Case Number: _____

(Please attach copies of health insurance cards to this form)

Name	DOB
Address	SSN
City, State, Zip	Custodial Parent

Name	DOB
Address	SSN
City, State, Zip	Custodial Parent

Name	DOB
Address	SSN
City, State, Zip	Custodial Parent

Name	DOB
Address	SSN
City, State, Zip	Custodial Parent

Name	DOB
Address	SSN
City, State, Zip	Custodial Parent

PARTIES	EMPLOYER INFO	INSURANCE INFO
(1) Name	Employer Name	Insurance Company
Address	Address	Address
City, State, Zip	City, State, Zip	City, State, Zip
DOB		Policy #
SSN		Group #

PARTIES	EMPLOYER INFO	INSURANCE INFO
(2) Name	Employer Name	Insurance Company
Address	Address	Address
City, State, Zip	City, State, Zip	City, State, Zip
DOB		Policy #
SSN		Group #

PARTIES	EMPLOYER INFO	INSURANCE INFO
(3) Name	Employer Name	Insurance Company
Address	Address	Address
City, State, Zip	City, State, Zip	City, State, Zip
DOB		Policy #
SSN		Group #