FLORIDA KIDCARE
INSURANCE ACCESS STATEMENT

General Directions: Complete this form and return it to:

Florida KidCare
P O Box 591
Tallahassee, FL 32302

Section A - Parent Info – Complete all blank information for each employed parent.

Family Account #: _____

Parent One Name:_____ **Parent One SSN:**_____

Parent One Employer Name: _____

Employer Phone: (_____)_____

Does _____'s employer offer health insurance for your children? __ Yes __ No

If yes, how much would it cost each month? $_____ (Please enter dollar amount)

Has _____ voluntarily cancelled their employer-sponsored health insurance for your children in the last 6 months? __ Yes __ No

Parent Two Name: _____**Parent Two SSN:** _____

Parent Two Employer Name: _____

Employer Phone: **(_____)**_____

Does _____'s employer offer health insurance for your children? __ Yes __ No

If yes, how much would it cost each month? $_____ (Please enter dollar amount)

Has_____ voluntarily cancelled their employer-sponsored health insurance for your children in the last 6 months? __ Yes __ No

Section B – Complete for all applicant children under 19 years old in household.

Child Name	**Child SSN**	**Could this child be covered under a health insurance plan offered by the employer of either parent one or parent two?**
		__ Yes __ No
		__ Yes __ No
		__ Yes __ No

PARENT STATEMENT: What I have written on this form is true to the best of my knowledge. I know that if I give false information on purpose, I may be subject to prosecution for fraud.

_____ _____ Parent Signature
Date

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