

SUPREME COURT
STATE OF NEW YORK
COUNTY OF ONONDAGA

_____,
(Print Your Name) Plaintiff,

-VS-

_____,
(Print Other Party's Name) Defendant.

**HEALTH INSURANCE COVERAGE
NOTIFICATION**

INDEX No.

***If There Is No Opting-Out Agreement or Separation Agreement,
The Court will mail a copy of this Notice to both parties***

NOTICE

Once the judgment of divorce is entered, a person may or may not be eligible to be covered under his or her former spouse's health insurance plan, depending on the terms of the plan.

***If There is an Opting-Out Agreement or Separation Agreement,
The Following Must be Completed and Signed***

I, (Print Plaintiff's Name) _____, fully understand that upon the entrance of this divorce agreement, I may no longer be allowed to receive health coverage under my former spouse's health insurance plan. I may be entitled to purchase health insurance on my own through a COBRA option, if available, otherwise I may be required to secure my own health insurance.

Date: (Print Date) _____

Sign Name
Plaintiff

I, (Print Defendant's Name) _____, fully understand that upon the entrance of this divorce agreement, I may no longer be allowed to receive health coverage under my former spouse's health insurance plan. I may be entitled to purchase health insurance on my own through a COBRA option, if available, otherwise I may be required to secure my own health insurance.

Date: (Print Date) _____

Sign Name
Defendant