connecting hearts
adoption services

HEALTH INSURANCE

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.

Please attach a copy of your health insurance card(s).

_____ _____
Applicant Signature Date

_____ _____
Applicant Signature Date

LIFE INSURANCE

Covering:_____Company: _____ Amount:_____

Covering:_____Company: _____ Amount:_____

Covering:_____Company: _____ Amount:_____

Covering:_____Company: _____ Amount:_____

Insurance Beneficiary: _____

Do you plan to add your adopted child(ren) as a beneficiary to your life insurance policy? _____YES ___NO

GUARDIANSHIP

Do you have a legal will? Yes _____ No _____ If yes, date of will: _____
I/ We have instructed the following person(s) to assume guardianship of my/our child(ren) should I/we be unable to care for them:

Name(s):	
Relationship:	
Address:	
Phone:	
Profession/Age Guardian 1:	
Profession/Age Guardian 2:	

_____ _____
Applicant Signature Date

_____ _____
Applicant Signature Date