IN THE CIRCUIT COURT IN THE EIGHTEENTH JUDICIAL CIRCUIT
IN AND FOR BREVARD COUNTY, FLORIDA.

Case No.: _____

_____, Bar Code Label
Petitioner

and

_____,
Respondent

ORDER FOR HEALTH INSURANCE COVERAGE

TO: ALL EMPLOYERS (OR FUTURE EMPLOYERS), or any other person providing health insurance coverage for OBLIGOR *{name of person who was ordered to provide health insurance}* _____:

YOU ARE HEREBY ORDERED TO:

1. Begin or maintain health insurance coverage on the child(ren). You may deduct any premium or costs from the wages or earnings of the OBLIGOR *{name of person who was ordered to provide health insurance}* _____.

2. If the OBLIGOR works for you, or if you have health insurance coverage available to OBLIGOR, you must give him or her a copy of this order within 10 days after you receive it.

3. If no health insurance coverage is available to the OBLIGOR, complete and sign the DECLARATION OF NO HEALTH INSURANCE COVERAGE form and mail the declaration within 20 days to the attorney or person requesting the insurance coverage.

DONE AND ORDERED at Brevard County, Florida, on the _____ day of _____, 200___.

_____
Circuit Judge

Cc:

Petitioner or their attorney (if represented)
Name_____
Address_____
_____
City State Zip

Respondent or their attorney (if represented)
Name_____
Address_____
_____
City State Zip

Obligor's Employer
Name_____
Address_____
_____
City State Zip

IF A NONLAWYER HELPED YOU FILL OUT THIS FORM TO GIVE TO THE JUDGE TO SIGN, THE NONLAWYER WHO HELPED YOU MUST FILL IN THE BLANKS BELOW: [✎ fill in all blanks]

I, *{full legal name and trade name of nonlawyer}* **_____,**

a nonlawyer, located at *{street}* _____, *{city}*_____,

*{state}*_____, *{phone}*_____, helped *{**Petitioner's** name}* _____,

_____, who [v **one** only] _____petitioner **or** _____ respondent,

fill out this form.