

**EXHIBIT A**

NAME OF PARTY: \_\_\_\_\_      MOVANT      RESPONDENT

PARTY'S ATTORNEY: CHRISTINE G. ALBANO

Beside the name of the child, check all types of health insurance or benefits currently covering the child. You may check more than one source.

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<b>Child's Name</b>	<b>Date of Birth</b>	<b>Social Security No.</b>
_____	_____	_____
<input type="checkbox"/> Father's	<input type="checkbox"/> Medicaid	<input type="checkbox"/> None
<input type="checkbox"/> Mother's	<input type="checkbox"/> CHIP	
<input type="checkbox"/> Private	<input type="checkbox"/> Other: _____	

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<b>Child's Name</b>	<b>Date of Birth</b>	<b>Social Security No.</b>
_____	_____	_____
<input type="checkbox"/> Father's	<input type="checkbox"/> Medicaid	<input type="checkbox"/> None
<input type="checkbox"/> Mother's	<input type="checkbox"/> CHIP	
<input type="checkbox"/> Private	<input type="checkbox"/> Other: _____	

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<b>Child's Name</b>	<b>Date of Birth</b>	<b>Social Security No.</b>
_____	_____	_____
<input type="checkbox"/> Father's	<input type="checkbox"/> Medicaid	<input type="checkbox"/> None
<input type="checkbox"/> Mother's	<input type="checkbox"/> CHIP	
<input type="checkbox"/> Private	<input type="checkbox"/> Other: _____	

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_____	_____	_____
<input type="checkbox"/> Father's	<input type="checkbox"/> Medicaid	<input type="checkbox"/> None
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<input type="checkbox"/> Private	<input type="checkbox"/> Other: _____	

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<b>Child's Name</b>	<b>Date of Birth</b>	<b>Social Security No.</b>
_____	_____	_____
<input type="checkbox"/> Father's	<input type="checkbox"/> Medicaid	<input type="checkbox"/> None
<input type="checkbox"/> Mother's	<input type="checkbox"/> CHIP	
<input type="checkbox"/> Private	<input type="checkbox"/> Other: _____	

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\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date