AFFIDAVIT OF NO INSURANCE
(Medical or Auto Insurance)

I, _____, due hereby swear that I have no medical health
(print name)
insurance for payment of medical bills associated with my injury sustained during my participation in or my involvement in the following:

( ) Motor vehicle accident **Date of Accident ____ / _____ / _____**

( ) Liability Claim or Slip and Fall **Date of Injury ____ / _____ / _____**

( ) No medical insurance for the current condition
Date of first treatment ____ / _____ /_____ Condition: _____

( ) Other: _____

_____

I hereby state that I am not qualified to collect for medical benefits under my name or under the policy of any relative with whom I may, or may not, reside with.

_____ _____ _____
(Print patient's name) (signature) (Date)

STATE OF FLORIDA
COUNTY OF _____
Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20___,
by _____(name of person making statement).

_____
(Signature of Notary Public-State of Florida)

_____
(Name of Notary Typed, Printed, or Stamped)

Personally Known _____ OR Produced Identification _____Type of Identification Produced_____