

NATIONAL MEDICAL SUPPORT NOTICE - PART B
NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

Issuing Agency: _____ Issuing Agency Address: _____ _____ Notice Date: _____ CSE Agency Case Identifier: _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ Order Date: _____ Order Identifier: _____ Document Tracking Number: _____ Employer web site: _____ See NMSN Instructions: www.acf.hhs.gov/programs/cse/forms/
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RE: _____

Employee's Name (Last, First, MI) _____

Employee's Social Security Number _____

Employee's Mailing Address _____

Substituted Official/Agency Name _____

Substituted Official/Agency Address _____

(Required if custodial parent's mailing address is left blank)

Mailing Address of a Representative of the Child(ren) _____

Child(ren)'s Name(s)	Gender	DOB	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

Case # _____ (to be completed by the Issuing Agency)

This Notice was received by the plan administrator on _____.

☐ 1. This Notice does not constitute a "qualified medical child support order" because:

- ☐ The name of the ☐ child(ren) or ☐ employee is unavailable.
- ☐ The mailing address of the ☐ child(ren) (or a substituted official) or ☐ employee is unavailable.
- ☐ The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan.

Last Name	First Name	Middle Name	Suffix	Gender	SSN

☐ 2. This Notice was determined to be a "qualified medical child support order," on _____.

Complete **Response 4 or 5, and 3**, if applicable.

☐ 3. The employee is subject to a waiting period that expires _____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the plan administrator will process the enrollment.

☐ 4. There is more than one option available under the plan and the employee is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the employee if necessary, will be enrolled in the plan's default option, if any: _____.

☐ 5. The employee and alternate recipient(s)/(child(ren)) are to be enrolled in the following family coverage.

- ☐ a. The child(ren) is/are currently enrolled in the plan as a dependent of the employee.
- ☐ b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the employee under the plan.
- ☐ c. The employee is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
- ☐ d. The employee is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of ____/____/____ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in options below (if plan is insured, identify provider, policy and group numbers).

Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

Total Number of All Dependents: _____

SECTION 1: MEDICAL INSURANCE

Insurance Provider Name NAIC Code Group Number Renewal Date

Insurance Provider Address Line 1 \$ Coverage Cost for Individual Cost Frequency

Insurance Provider Address Line 2 \$ Coverage Cost for Listed Children Cost Frequency

Insurance Provider City State Zip Code Zip Code Ext.

Complete the following information for each dependent

Name (Last, First, Middle)	Gender	Social Security Number	Date of Birth	Policy Number	Start Date	End Date

Medical Insurance Coverage also includes: (Check all that apply)

☐ Dental ☐ Vision ☐ Prescription ☐ Mental Health ☐ Other: (Specify) _____

SECTION 2: DENTAL INSURANCE

Insurance Provider Name NAIC Code Group Number Renewal Date

Insurance Provider Address Line 1 \$ Coverage Cost for Individual Cost Frequency

Insurance Provider Address Line 2 \$ Coverage Cost for Listed Children Cost Frequency

Insurance Provider City State Zip Code Zip Code Ext.

Complete the following information for each dependent

Name (Last, First, Middle)	Gender	Social Security Number	Date of Birth	Policy Number	Start Date	End Date

SECTION 3: VISION INSURANCE

Insurance Provider Name

NAIC Code

Group Number

Renewal Date

Insurance Provider Address Line 1

\$

Coverage Cost for Individual

Cost Frequency

Insurance Provider Address Line 2

\$

Coverage Cost for Listed Children

Cost Frequency

Insurance Provider City

State

Zip Code

Zip Code Ext.

Complete the following information for each dependent

Name (Last, First, Middle)	Gender	Social Security Number	Date of Birth	Policy Number	Start Date	End Date

SECTION 4: PRESCRIPTION DRUG INSURANCE

Insurance Provider Name

NAIC Code

Group Number

Renewal Date

Insurance Provider Address Line 1

\$

Coverage Cost for Individual

Cost Frequency

Insurance Provider Address Line 2

\$

Coverage Cost for Listed Children

Cost Frequency

Insurance Provider City

State

Zip Code

Zip Code Ext.

Complete the following information for each dependent

Name (Last, First, Middle)	Gender	Social Security Number	Date of Birth	Policy Number	Start Date	End Date

SECTION 5: MENTAL HEALTH INSURANCE

Insurance Provider Name

NAIC Code

Group Number

Renewal Date

Insurance Provider Address Line 1

\$
Coverage Cost for Individual

Cost Frequency

Insurance Provider Address Line 2

\$
Coverage Cost for Listed Children

Cost Frequency

Insurance Provider City

State

Zip Code

Zip Code Ext.

Complete the following information for each dependent

Name (Last, First, Middle)	Gender	Social Security Number	Date of Birth	Policy Number	Start Date	End Date

SECTION 6: OTHER INSURANCE

Insurance Provider Name

NAIC Code

Group Number

Renewal Date

Insurance Provider Address Line 1

\$
Coverage Cost for Individual

Cost Frequency

Insurance Provider Address Line 2

\$
Coverage Cost for Listed Children

Cost Frequency

Insurance Provider City

State

Zip Code

Zip Code Ext.

Complete the following information for each dependent

Name (Last, First, Middle)	Gender	Social Security Number	Date of Birth	Policy Number	Start Date	End Date

Plan Administrator or Representative:

Name: _____

Telephone Number: _____

Title: _____

Date: _____

Address: _____

INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the **employee** identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the **employee** is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on **Part B**.

(A) If the **employee** and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a “qualified medical child support order”(QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 business days of the date of this Notice, or sooner if reasonable:

(1) Complete Part B - Plan Administrator Response - and send it to the Issuing Agency:

(a) if you checked **Response 5**:

- (i) notify the **employee** named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);
- (ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;

(b) if you checked **Response 4**:

- (i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional **employee** contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;
- (ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency.

(c) if the **employee** is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete **Response 3** on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the **employee** and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under **Response 4 or 5**, and

(d) upon completion of the enrollment, transfer the applicable information on Part B - Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

(B) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete **Response 1 of Part B - Plan Administrator Response** and send it to the Issuing Agency, and inform the **employee**, custodial parent, and child(ren) of the specific reasons for your determination.

(C) Any required notification of the custodial parent, child(ren) and/or **employee** may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate. You may choose to furnish these notifications electronically in accordance with the requirements of the Department of Labor's electronic disclosure regulation codified at 29 CFR 2520.104b-1(c).

UNLAWFUL REFUSAL TO ENROLL

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the **employee's** Federal income tax return; (3) the child does not reside with the **employee** or in the plan's service area; or (4) because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the **employee** be enrolled in order for the child(ren) to be enrolled, and the **employee** is not currently enrolled, you must enroll both the **employee** and the child(ren) regardless of whether the **employee** has applied for enrollment in the plan. All enrollments are to be made without regard to open season restrictions.

PAYMENT OF CLAIMS

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

PERIOD OF COVERAGE

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

- (1) The plan administrator is provided satisfactory written evidence that either:
 - (a) the court or administrative child support order referred to above is no longer in effect, or
 - (b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;
- (2) The employer eliminates family health coverage for all of its employees; or
- (3) Any available continuation coverage is not elected, or the period of such coverage expires.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

Paperwork Reduction Act Notice

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act or the Child Support Performance and Incentive Act, as applicable. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

<u>Learning about the law or the form</u>		<u>Preparing the form</u>
First Notice	1 hr. ____	1 hr., 45 min.
Subsequent Notices	-----	20 min.