

**HIGHLIGHTED VERSION – CHANGES ARE IN GRAY SHADED AREAS**

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

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998 (CSPIA). Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law. The information on the custodial parent and child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. **NOTE: For purposes of this form, the custodial parent may also be the employee when the State opts to enforce against the custodial parent.**

Issuing Agency: _____ Issuing Agency Address: _____ _____ <b>Notice Date:</b> _____ <b>CSE Agency Case Identifier:</b> _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ <b>Order Date:</b> _____ <b>Order Identifier:</b> _____ <b>Document Tracking Number:</b> _____ Employer web site: _____ <b>See NMSN Instructions:</b> <a href="http://www.acf.hhs.gov/programs/cse/forms/">www.acf.hhs.gov/programs/cse/forms/</a>
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\_\_\_\_\_  
Employer/Withholder's Federal EIN Number

\_\_\_\_\_  
Employer/Withholder's Name

\_\_\_\_\_  
\_\_\_\_\_  
Employer / Withholder's Address

\_\_\_\_\_  
Custodial Parent's Name (Last, First, MI)

\_\_\_\_\_  
\_\_\_\_\_  
Custodial Parent's Mailing Address

\_\_\_\_\_  
Child(ren)'s Mailing Address (if different from  
custodial parent's)

\_\_\_\_\_  
Name and Telephone of a Representative of the  
Child(ren)

Child(ren)'s Name(s)	<b>Gender</b>	DOB	SSN
_____	_____	_____	_____
_____	_____	_____	_____

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)	<b>Gender</b>	DOB	SSN
_____	_____	_____	_____
_____	_____	_____	_____

The order requires the child(ren) to be enrolled in  **all** health coverages available; or only the following coverage(s):  
 Medical;  Dental;  Vision;  Prescription drug;  Mental health;  Other specify: \_\_\_\_\_

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. **OMB control number: 1210-0113 Expiration Date: 03/31/2014.**

**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.