NATIONAL MEDICAL SUPPORT NOTICE - PART A
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. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable 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 have policies to enforce against custodial parents.

☐ **National Medical Support Order/Notice (NMSN)** ☐ **Termination Order/Notice - if checked, see page 2**

Notice Date: [GENERATION_DT] Issuing Agency: [OFFICE_NAME_ACRONYM] Address: [OFFICE_MAIL_ADDRESS] **Case Identifier**: [CSE_CASE_NUMBER] Telephone Number: [OFFICE_PHONE] Email Address: [OFFICE_EMAIL] FAX Number: [OFFICE_FAX]	Court or Administrative Authority: [COURT_FULL_NAME] Order Date: [ORDER_DATE] Order Identifier: [COURT_CASE_NUMBER] Document Tracking Identifier: [DOC_TRACKING_ID_TEXT] Employer website: [EMPLOYER_WEB_SITE_TEXT] See NMSN Instructions: https://www.acf.hhs.gov/sites/default/files/documents/ocse/omb_0970-0222_a_instructions.pdf

RE:

[EMPLOYER_FEIN]
Employer/Withholder's Federal EIN Number

[OBLIGOR_NAME]
Employee's Name (Last, First, MI)

[EMPLOYER_PR_NAME]
Employer/Withholder's Name

[OBLIGOR_SSN]
Employee's Social Security Number

[EMPLOYER_MAILING_ADDRESS]
Employer/Withholder's Address

[OBLIGOR_MAILING_ADDRESS]
Employee's Mailing Address

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

[OFFICE_NAME]
Substituted Official/Agency Name

Custodial Parent's Mailing Address

[OFFICE_MAIL_ADDRESS]
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

Child(ren)'s Mailing Address (if different from Custodial Parent's)

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

Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN
[DEPENDENT_NAME_1]	[G_1]	[DOB_1]	xxx-xx-0045	[DEPENDENT_NAME_5]	[G_5]	[DOB_5]	xxx-xx-0045
[DEPENDENT_NAME_2]	[G_2]	[DOB_2]	xxx-xx-0045	[DEPENDENT_NAME_6]	[G_6]	[DOB_6]	xxx-xx-0045
[DEPENDENT_NAME_3]	[G_3]	[DOB_3]	xxx-xx-0045	[DEPENDENT_NAME_7]	[G_7]	[DOB_7]	xxx-xx-0045
[DEPENDENT_NAME_4]	[G_4]	[DOB_4]	xxx-xx-0045	[DEPENDENT_NAME_8]	[G_8]	[DOB_8]	xxx-xx-0045

The order requires the child(ren) to be enrolled in ☐ all health coverages available; or only the following coverage:

☐ Medical; ☐ Dental; ☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐ Other specify:

[OTHER_COVERAGE_TEXT]

LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed [LIMIT_TX] % of the employee's aggregate disposable weekly earnings. The employer may not withhold more under this National Medical Support Notice than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));

2. The amounts allowed by the State of the employee's principal place of employment; or

3. The amounts allowed for health insurance premiums by the child support order, as indicated here: [PAGE_2_HEALTH_PREMIUM_TEXT].

PRIORITY OF WITHHOLDING

In addition to the limitations on withholding that determine the maximum amount of earnings the employer may withhold for paying support, each state has policy or law which prioritizes the kinds of support to be paid. **If the employee does not earn enough to pay all ordered support, then the employer should consult the state's priority of withholding to determine the order of importance between all orders for current support, medical support, support arrears, and interest on the support arrears.** The employer must consider all support orders received for each employee.

For more information about specific state and territory limitations and priority of withholding, see the OCSE Medical Support Matrix at **https://www.acf.hhs.gov/css/contact-information/state-medical-support-contacts-and-requirements.**

[WITHHOLDING_PRIORITY_TEXT]

Additional Information for Termination Order/Notice

Unless the employee has indicated that they want to continue coverage voluntarily, you are required to terminate health care coverage for the child(ren) identified in this NMSN order/notice if the Termination Order/Notice checkbox is checked on page 1.

1. Effective date of medical support order/notice termination: [TERMINATION_DATE]

2. Reason for termination of order/notice: [REASON_FOR_TERMINATION_TEXT]

3. Child(ren) for whom the order/notice is terminated:

Last, First, Middle Name of Child(ren):	DOB:
[TERMINATION_DEPENDENT_NAME_1]	[TERMINATION_DOB_1]
[TERMINATION_DEPENDENT_NAME_2]	[TERMINATION_DOB_2]
[TERMINATION_DEPENDENT_NAME_3]	[TERMINATION_DOB_3]
[TERMINATION_DEPENDENT_NAME_4]	[TERMINATION_DOB_4]
[TERMINATION_DEPENDENT_NAME_5]	[TERMINATION_DOB_5]
[TERMINATION_DEPENDENT_NAME_6]	[TERMINATION_DOB_6]
[TERMINATION_DEPENDENT_NAME_7]	[TERMINATION_DOB_7]
[TERMINATION_DEPENDENT_NAME_8]	[TERMINATION_DOB_8]

EMPLOYER RESPONSE

Section 1 - No Enrollment Possible

The employer knows that the plan administrator cannot enroll dependents in employer-provided health care coverage for the employee named on page 1, because: (select all that apply)

☐ 1. The employee named in this Notice has never been employed by this employer.

☐ 2. We, the employer, do not offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.

☐ 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health care coverage under any group health care plan maintained by the employer or to which the employer contributes. **If the employee is only temporarily ineligible for health care coverage, do not check this box, and advance to Section 2.**

☐ 4. Health care coverage is not available because employee is no longer employed here:

Effective date of separation: _____

Reason for separation: _____

Last known telephone number: _____

Last known address: _____

(If new employment information is known, add at #6).

☐ 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan. (*See page 2 for description and instructions.)*

☐ 6. Other (new job information for employee, child adequately covered by 3rd party, other reason for no coverage):_____

Section 2 - Dependent Enrollment Not Yet Available

☐ 7. The participant 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.

☐ 8. Employee is on an unpaid leave of absence. Expected date of return:_____

Section 3 - Dependent Coverage Available

☐ 9. Employer forwarded Part B - Medical Support Notice to Plan Administrator on this date: _____

COMPLETED BY:

Employer Company Name:	Plan Administrator Company / Union Name:
[EMPLOYER_PR_NAME]	_____
Contact Name:_____	Contact Name:_____
Title:_____	Title:_____
Email:_____	Email:_____
Telephone:_____	Telephone:_____
FAX:_____	FAX:_____
FEIN:_____	FEIN:_____

NOTICE AND GENERAL INSTRUCTIONS TO EMPLOYER

This document serves as legal notice that the employee identified on this National Medical Support Notice is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified on this Notice. This National Medical Support Notice replaces any Medical Support Notice that the Issuing Agency has previously served on you with respect to the employee and the children listed on this Notice.

The document consists of

1. **Part A - Notice to Withhold for Health Care Coverage** for the employer to withhold any employee contributions required by the group health care plan(s) in which the child(ren) is/are enrolled; and
2. **Part B - Medical Support Notice to Plan Administrator**, which **must** be forwarded to the Administrator of each group health care plan identified by the employer to enroll the eligible child(ren), or completed by the employer, if the employer serves as the health care Plan Administrator.

An employer receiving this legal Notice is required to complete and return Part A - Employer Response. If group health care coverage is not available to the employee named herein, or the employee was never or is no longer employed, the employer is required to complete Part A - Employer Response and return it to the Issuing Agency with the appropriate response checked.

If you, the employer, provide the health care benefits to the employee, forward Part B - Medical Support Notice to Plan Administrator - Plan Administrator Response to the health care Plan Administrator of your organization. If the employee's health care benefits are administered through another organization, including a labor union, forward Part B - Medical Support Notice to Plan Administrator to the labor union or other organization acting as the Plan Administrator for completion. **If the employee has already enrolled the child(ren) in health care coverage, the employer must forward Part B - Medical Support Notice to Plan Administrator to the Plan Administrator for completion and submittal to the Issuing Agency.**

Keep a copy of **Part A - Notice to Withhold for Health Care Coverage** to notify the Issuing Agency if the employee separates from service for any reason including retirement or termination. You may also use Part A to notify the Issuing Agency of any changes or lapses in health care coverage.

For step-by-step supplemental instructions, see https://www.acf.hhs.gov/sites/default/files/documents/ocse/omb_0970-0222_a_instructions.pdf

EMPLOYER RESPONSIBILITIES

1. If dependent health care coverage is available for which the child(ren) identified above may be eligible, you are required to:

   a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to Plan Administrator** to the Administrator of each appropriate group health care plan for which the child(ren) may be eligible, complete Section 3, item 9, and

   b. Upon notification from the Plan Administrator(s) whether the child(ren) is/are enrolled or cannot be enrolled, either

      1) withhold from the employee's income any employee contributions required under each group health care plan, in accordance with the applicable law of the employee's principal place of employment and transfer employee contributions to the appropriate plan(s), or

      2) complete Section 1, item 5, of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

   c. If the Plan Administrator notifies you that the employee is subject to a waiting period that expires more than 90 days from the date of its receipt of **Part B - Medical Support Notice to Plan Administrator**, or 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 Section 2, item 7, of the Employer Response to notify the Issuing Agency of the enrollment timeframe and notify the Plan Administrator when the employee is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice in the plan.

2. If the Termination Order/Notice checkbox is checked, you are required to terminate the NMSN/Qualified Medical Child Support Order (QMCSO) and health care coverage for the child(ren) identified in the order **unless the employee has indicated that they want to continue coverage voluntarily.** If this employee is also under a wage withholding order for payment of child support, release of this health care insurance order may result in an increase in the amount of earnings available to remit to the state disbursement unit as child support. Release of this health care insurance order does not negate your obligation to comply with wage withholding and/or other health care insurance orders for this employee.

DURATION OF WITHHOLDING

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when conditions for eligibility for coverage under terms of the plan no longer apply. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. **The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:**

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

POSSIBLE SANCTIONS

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s) as the Notice directs. Sanctions or penalties may be imposed under State law against an employer for failure to respond and/or for non-compliance with this Notice.

NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the above employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending to the Issuing Agency a copy of **Part A - Notice to Withhold for Health Care Coverage**, with Section 1, item 4, checked or any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act.

EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest the withholding under this Notice based on a mistake of fact (such as the identity of the obligor). Should an employee contest the withholding under this Notice, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. **To contest the withholding under this Notice, the employee should contact the Issuing Agency at the address and telephone number listed on page 1 of this Notice**. With respect to plans subject to ERISA, it is the view of the Department of Labor that Federal Courts have jurisdiction if the employee challenges a determination that the Notice constitutes a Qualified Medical Child Support Order.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed on page 1 of this Notice.

For Frequently Asked Questions (FAQs) about the NMSN, see Resource Library | The Administration for Children and Families (hhs.gov)

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NATIONAL MEDICAL SUPPORT NOTICE - PART B
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

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 have policies to enforce against the Custodial Parent.

Notice Date: [GENERATION_DT] Issuing Agency: [OFFICE_NAME_ACRONYM] Address: [OFFICE_MAIL_ADDRESS] Case Identifier: [CSE_CASE_NUMBER] Telephone Number: [OFFICE_PHONE] Email Address: [OFFICE_EMAIL] FAX Number: [OFFICE_FAX]	Court or Administrative Authority: [COURT_FULL_NAME] Order Date: [ORDER_DATE] Order Identifier: [COURT_CASE_NUMBER] Document Tracking Identifier: [DOC_TRACKING_ID_TEXT] Employer web site: [EMPLOYER_WEB_SITE_TEXT] See NMSN Instructions: https://www.acf.hhs.gov/css/form/national-medical-support-notice-forms-instructions

[EMPLOYER_FEIN]
Employer/Withholder's Federal EIN Number

RE: [OBLIGOR_NAME]
Employee's Name (Last, First, MI)

[EMPLOYER_PR_NAME]
Employer/Withholder's Name

[OBLIGOR_SSN]
Employee's Social Security Number

[EMPLOYER_MAILING_ADDRESS]
Employer/Withholder's Address

[OBLIGOR_MAILING_ADDRESS]
Employee's Mailing Address

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

[OFFICE_NAME]
Substituted Official/Agency Name

Custodial Parent's Mailing Address

[OFFICE_MAIL_ADDRESS]
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

Child(ren)'s Mailing Address (if different from Custodial Parent's)

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

Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN
[DEPENDENT_NAME_1]	[G_1]	[DOB_1]	111-41-0045	[DEPENDENT_NAME_5]	[G_5]	[DOB_5]	111-41-0045
[DEPENDENT_NAME_2]	[G_2]	[DOB_2]	111-41-0045	[DEPENDENT_NAME_6]	[G_6]	[DOB_6]	111-41-0045
[DEPENDENT_NAME_3]	[G_3]	[DOB_3]	111-41-0045	[DEPENDENT_NAME_7]	[G_7]	[DOB_7]	111-41-0045
[DEPENDENT_NAME_4]	[G_4]	[DOB_4]	111-41-0045	[DEPENDENT_NAME_8]	[G_8]	[DOB_8]	111-41-0045

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):

[OTHER_COVERAGE_TEXT]

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) No persons are required to respond to a collection of information unless it displays a valid OMB control number. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete the review of the information collection. **OMB control number: 1210-0113. OMB Expiration Date: 11/30/2025.**

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 this date _____.

1. ☐ This Notice was determined to be a "qualified medical child support order, " on this date _____. Complete **Response 2 or 3, and 4,** if applicable.

2. ☐ The participant (employee) and alternate recipient(s) (child(ren)) are or will be enrolled in the following family coverage:

a. ☐ The child(ren) is/are currently enrolled in the plan as a dependent of the participant.

b. ☐ There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.

c. ☐ The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.

d. ☐ The participant 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 the following option:_____ (if plan is insured, provider, policy and group numbers, and addresses for submitting claims, are provided in Addendum Section 1). Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

3. ☐ There is more than one option available under the plan and the participant 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 participant if necessary, will be enrolled in the plan's default option, if any:_____ (if plan is insured, see Addendum Section 1.)

4. ☐ The participant 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.

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

☐ The name of the child(ren) or participant is unavailable.

☐ The mailing address of the child(ren) (or a substituted official) or participant is unavailable.

☐ The child(ren) identified in the Addendum Section 2 is/are at or above the age at which dependents are no longer eligible for coverage under the plan.

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____ Email Address: _____

[EMPLOYER_PR_NAME] RE: [NCP_PRIMARY_NAME] [PARTICIPANT_NUMBER]

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 noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant 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 participant 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 2, complete Addendum Section 1 and:

(i) notify the noncustodial parent/participant 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); and

(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 3:

(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 participant 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. You must complete Addendum Section 1.

(c) if the participant 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 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, 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 5 of Part B - Plan Administrator Response and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination. Identify child(ren) at or above the age at which dependents are no longer eligible for coverage under the plan in Addendum Section 2.

(C) Any required notification of the custodial parent, child(ren) and/or participant 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 C.F.R. 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 participant's Federal income tax return; (3) the child does not reside with the participant 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 participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, you must enroll both the participant and the child(ren) regardless of whether the participant 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 (Part B, Page 1).

For more information, including Medical Support - FAQs for answers to employers' common questions, *see* https://www.acf.hhs.gov/css/form/national-medical-support-notice-forms-instructions. *See also* Medical Support Enforcement Policy Clarifications, https://www.acf.hhs.gov/css/policy-guidance/medical-support enforcement-policy-clarifications.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately 30 minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Research and Analysis, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0113. OMB Expiration Date: **11/30/2025.** Please do not send the National Medical Support Notice (NMSN) response to these DOL addresses. **You must return the response to the child support agency that issued the NMSN to your organization. The child support agency's contact information is on Page 1, Part B.**

NATIONAL MEDICAL SUPPORT NOTICE - ADDENDUM TO PART B

Notice Date: [GENERATION_DT] Issuing Agency: [OFFICE_NAME_ACRONYM] Address: [OFFICE_MAIL_ADDRESS] Case Identifier: [CSE_CASE_NUMBER] Telephone Number: [OFFICE_PHONE] Email Address: [OFFICE_EMAIL] FAX Number: [OFFICE_FAX]	Court or Administrative Authority: [COURT_FULL_NAME] Order Date: [ORDER_DATE] Order Identifier: [COURT_CASE_NUMBER] Document Tracking Identifier: [DOC_TRACKING_ID_TEXT] Employer web site: [EMPLOYER_WEB_SITE_TEXT] See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

SECTION 1: HEALTH INSURANCE DETAILS

Use section 1-1 through 1-6 to provide the information on the plans in which child(ren) is/are enrolled. Complete all of the following information for each type of health care coverage that the child(ren) is receiving (enrolled in) and attach this document to the completed PLAN ADMINISTRATOR RESPONSE.

SECTION 1-1: MEDICAL INSURANCE

Effective Date of Coverage: _____

Insurance Provider Name _____ Group Number _____ Policy Number _____

Insurance Provider Claims Address Line 1 _____ Insurance Provider Claims Address Line 2 _____

Insurance Provider Claims City _____ State _____ Zip Code _____ Phone Number for Claims _____

Medical Insurance Coverage Also Includes: (Check all that apply)

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

SECTION 1-2: DENTAL INSURANCE

Effective Date of Coverage: _____

Insurance Provider Name _____ Group Number _____ Policy Number _____

Insurance Provider Claims Address Line 1 _____ Insurance Provider Claims Address Line 2 _____

Insurance Provider Claims City _____ State _____ Zip Code _____ Phone Number for Claims _____

SECTION 1-3: VISION INSURANCE

Effective Date of Coverage: _____

Insurance Provider Name _____ Group Number _____ Policy Number _____

Insurance Provider Claims Address Line 1 _____ Insurance Provider Claims Address Line 2 _____

Insurance Provider Claims City _____ State _____ Zip Code _____ Phone Number for Claims _____

SECTION 1-4: PRESCRIPTION DRUG INSURANCE Effective Date of Coverage:_____

Insurance Provider Name | Group Number | Policy Number

Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

SECTION 1-5: MENTAL HEALTH INSURANCE Effective Date of Coverage:_____

Insurance Provider Name | Group Number | Policy Number

Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

SECTION 1-6: OTHER INSURANCE Effective Date of Coverage:_____

Insurance Provider Name | Group Number | Policy Number

Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

SECTION 2: NO LONGER ELIGIBLE CHILDREN DETAILS

Use below section to list child(ren) who are at or above the age at which dependents are no longer eligible for coverage under the plan.

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