PLEASE CAREFULLY READ ALL DOCUMENTS IMMEDIATE ACTION REQUIRED

The enclosed National Medical Support Notice (NMSN) has been sent to you in accordance with Title 45 of the Code of Federal Regulations, Part 303.32 because your employee is required to provide health care coverage for his/her dependent(s) if available at a reasonable cost. "Reasonable cost" to an obligor is defined by Rule 1910.16-6 (3)(i) as an amount that does not exceed 5% of the obligor's net monthly income and, when added to the amount of basic child support plus additional expenses the obligor is ordered to pay, does not exceed 50% of the obligor's net monthly income.

Enrollment shall not occur earlier than 25 days from the date of this notice to allow the employee time to object to the issuing court or Domestic Relations Section.

Please be advised that receipt of this NMSN constitutes legal process of service. The person or entity receiving this information is required to make every effort to ensure that these documents are submitted to the proper authority for completion. Failure of an employer or organization to comply with a NMSN may result in legal action.

Employer Requirements:

If dependent health care coverage **is not available** to the employee named in the NMSN, or the employee is no longer in your employ, complete the Employer Response and return it with Part A to the **Issuing Agency within 20 business days from date on the notice.**

If dependent health care coverage **is available** to the employee, complete and return the Addendum to Part A to the Issuing Agency. Forward Part B of the NMSN, Instructions to the Plan Administrator and the Addendum to Part B to the insurance Plan Administrator(s).

If you are the employer of an individual named herein who maintains or contributes to health care benefits that are administered through another organization or union, you must forward a copy of this letter, Part B, Instructions to the Plan Administrator and the Addendum to Part B, to the organization or union providing those benefits and/or acting as the Plan Administrator for completion.

Plan Administrators and unions providing benefits are required to:

Review and complete Part B of the NMSN and the Addendum to Part B. Return the completed documents to the **Issuing Agency within 40 business days from date on the notice.**

Note: *Part B of the Notice must be completed and submitted even if the health care benefits are already being provided.

The maximum amount of any attachment for child and medical support is set forth by the federal Consumer Credit Protection Act (Public Law 90-321, Section 303(b)). Priority of payment under any order for support shall be for cash support followed by medical support, which includes health insurance and related costs, capped at the maximum amount permitted by federal withholding law.

Employers should register on Pennsylvania's Child Support Program website at www.childsupport.state.pa.us to obtain more information about the form and its use. Select the "Employer" link from the center of the page and complete the registration screen. To indicate that you do not want to receive the NMSN instructions in future mailings or to report that dependent health care coverage is not available to any of your employees, contact the Bureau of Child Support Enforcement at 1-800-932-0211 for additional assistance.

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 (CSPIA). 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 enforce against the Custodial Parent.

Issuing Agency: _____	Court or Administrative Authority: _____
Issuing Agency Address: _____	Order Date: _____
Notice Date: _____	Order Identifier: _____
CSE Agency Case Identifier: _____	Document Tracking Identifier: _____
Telephone Number: _____	Employer web site: www.childsupport.state.pa.us
FAX Number: _____	See NMSN Instructions: www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE: _____

_____
Employer/Withholder's Federal EIN Number

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

_____
Employer/Withholder's Name

_____
Employee's Social Security Number

_____
Employer/Withholder's Address

_____
Employee's Mailing Address

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

_____
Substituted Official/Agency Name

_____
Custodial Parent's Mailing Address

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

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

_____
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

The order requires the child(ren) to be enrolled in [X] all health coverages available; or [ ] only the following coverage(s): __Medical; __Dental; __Vision; __Prescription drug; __Mental health; __Other (specify):_____

OMB control number: 0970-0222 Expiration Date: 08/31/2019

LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed **50%** 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: _____.

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes. As required under section 2.b.2 of the Employer Responsibilities on page 5, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support, as described here: **If there are multiple support obligations in effect against the income of the obligor, the court shall allocate among the obligees the amount of income available for withholding, giving priority to current child support to the limit provided by law.** As required under section 2.b.2 of the Employer Responsibilities on page 5, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

EMPLOYER RESPONSE

If 1, 2, 3, 4 or 5 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If 1 through 5 does not apply, complete item 7 and forward **Part B** to the appropriate Plan Administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. This includes any organization or labor union that provides group health care benefits to the employee. Check number 5 and return this **Part A** to the **Issuing Agency** if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization. You are required to respond to the Issuing Agency by returning this **Employer Response** regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization. Information for the Plan Administrator and the Employer Representative at the bottom of this section is required.

○ 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 coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.

○ 4. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: _____

Last known telephone number: _____

Last known address: _____

New employer (if known): _____

New employer telephone number: _____

New employer address: _____

○ 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.

○ 6. 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.

○ 7. Employer forwarded Part B to Plan Administrator on _____.
MM/DD/YY

CONTACT FOR QUESTIONS

Plan Administrator Name: _____
Contact Person: _____

FAX Number: _____
Telephone Number: _____

Employer Name: _____
Employer Representative Name/Title: _____

Telephone Number: _____
Federal EIN: _____
(if not provided on Page 1 of this Notice)

Employee Name: _____

Date: _____

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

An employer receiving this legal Notice is required to complete and return **Part A**. If group health coverage is not available to the employee named herein, or the employee was never or is no longer employed, the employer is still 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 - Plan Administrator Response** to the health Plan Administrator of your organization. If the employee's health care benefits are administered through another organization, including a labor union, forward Part B of the Notice 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 to the Plan Administrator for completion and submittal to the Issuing Agency.

Keep a copy of **Part A** as it may be used to notify the Issuing Agency if the employee separates from service for any reason including retirement or termination.

EMPLOYER RESPONSIBILITIES

1. If the individual named in this Notice is not your employee, or if family health care coverage is not available, please complete item 1, 2, 3, 4 or 5 of the Employer Response as appropriate, and return it to the Issuing Agency. NO FURTHER ACTION IS NECESSARY.
   If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:
2.

   a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to the Plan Administrator** to the administrator of each appropriate group health plan for which the child(ren) may be eligible, complete item 7, and
   b.
   Upon notification from the Plan Administrator(s) that the child(ren) is/are enrolled, either

      1) withhold from the employee's income any employee contributions required under each group health 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

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

   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** of this Notice, 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 item 6 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.

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 coverage for all of its employees.

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 with response 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 the 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 2 of this Notice.

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 enforce against the Custodial Parent.

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 Identifier: _____ Employer web site: www.childsupport.state.pa.us See NMSN Instructions: www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE:

_____
Employer/Withholder's Federal EIN Number

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

_____
Employer/Withholder's Name

_____
Employee's Social Security Number

_____
Employer/Withholder's Address

_____
Employee's Mailing Address

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

_____
Substituted Official/Agency Name

_____
Custodial Parent's Mailing Address

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

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

_____
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

The order requires the child(ren) to be enrolled in [X] 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 20 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: 08/31/2019.

Service Type

Worker ID

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)

This Notice was received by the plan administrator on _____.

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

2. The participant (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 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, 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.

☐ 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: _____.

☐ 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 following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan _____ (insert name(s) of child(ren)).

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 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:

(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);

(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.

(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.

(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.

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.

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.

	Learning about the law or the form	**Preparing the form**
First Notice	1 hr.	1 hr., 45 min.
Subsequent Notices	-----	20 min.

NATIONAL MEDICAL SUPPORT NOTICE

ADDENDUM to PART A - EMPLOYER RESPONSE

Use ONLY when enforcing a Pennsylvania medical support order

Employer/Withholder's Federal EIN Number	RE: Employee's Name (Last, First, MI)
Employer/Withholder's Name	Employee's Social Security Number
Employer/Withholder's Address	Employee's Mailing Address
Custodial Parent's Name (Last, First, MI)	Substituted Official/Agency Name
Custodial Parent's Mailing Address	Substituted Official/Agency Address

FOR COMPLETION BY THE EMPLOYER

Please provide the following information regarding the Plan Administrators, who you sent both **Part B - Medical Support Notice to Plan Administrator** and **Addendum to Part B - Plan Administrator Response**. Each administrator of each group health plan shall be sent both **Part B** and the **Addendum to Part B**. If more than one Plan Administrator is indicated, photocopy **Part B - Medical Support Notice to Plan Administrator** and **Addendum to Part B - Plan Administrator Response** and send both forms to each Plan Administrator.

NAME	ADDRESS	TELEPHONE #

Return this form to the ISSUING AGENCY named below within 20 business days after the date shown on the National Medical Support Notice to inform the ISSUING AGENCY about what action has occurred.

REMINDER: Report immediately to the ISSUING AGENCY any change in coverage availability that occurs in the future for any child(ren) named in **Part A**.

Employer Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

EIN (if not provided by Issuing Agency on Notice to Withhold for Health Care Coverage): _____

FOR OFFICIAL USE ONLY

Issuing Agency: _____ Issuing Agency Address: _____ Notice Date: _____ CSE Agency Case Identifier: _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ Order Date: _____ Order Identifier: _____ Member ID: _____

Service Type

Form EN-027 03/17

Worker ID

NATIONAL MEDICAL SUPPORT NOTICE

ADDENDUM to PART B - PLAN ADMINISTRATOR RESPONSE

Use ONLY when enforcing a Pennsylvania medical support order

RE:

Employer/Withholder's Federal EIN Number

Employee's Name (Last, First, MI)

Employer/Withholder's Name

Employee's Social Security Number

Employer/Withholder's Address

Employee's Mailing Address

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

Substituted Official/Agency Name

Custodial Parent's Mailing Address

Substituted Official/Agency Address

FOR COMPLETION BY THE PLAN ADMINISTRATOR

If there is more than one coverage option, photocopy **Part B** before you forward it to the Issuing Agency. Complete and return this page with **Part B** when enrollment is completed. Keep a copy of the form for your records.

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

For all applicable coverages, provide the insurance company name, address, policy number, and group number for each type of coverage.

	Insurance Company Name and Address	Policy #	Group #
Medical:			
Dental:			
Vision:			
Prescription drug:			
Mental health:			
Other (specify):			

The child(ren) may not be disenrolled (or coverage eliminated) unless one of the conditions applies that is listed in the **Instructions to Plan Administrator** under the section **"Period of Coverage"** or the employee is no longer eligible for family health coverage due to a change in his/her employment status.

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____

FOR OFFICIAL USE ONLY

Issuing Agency: _____

Issuing Agency Address:

_____

Notice Date: _____

CSE Agency Case Identifier: _____

Telephone Number: _____

FAX Number: _____

Court or Administrative Authority: _____

Order Date: _____

Order Identifier: _____

Member ID: _____

Service Type

Worker ID