

**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**

<b>Notice Date:</b> _____	Court or Administrative Authority: _____
Issuing Agency: _____	Order Date: _____
Address: _____	Order Identifier: _____
<b>Case Identifier:</b> _____	Document Tracking Identifier: _____
Telephone Number: _____	Employer website: _____
Email Address: _____	See NMSN Instructions:
Fax Number: _____	<a href="https://www.acf.hhs.gov/sites/default/files/documents/ocse/omb_0970-0222_a_instructions.pdf">https://www.acf.hhs.gov/sites/default/files/documents/ocse/omb_0970-0222_a_instructions.pdf</a>

_____	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
_____	_____
_____	Substituted Official/Agency Name
Custodial Parent's Name (Last, First, MI)	_____
_____	_____
_____	Substituted Official/Agency Address
Custodial Parent's Mailing 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
_____	_____
_____	_____
_____	_____
_____	_____

The order requires the child(ren) to be enrolled in  all health care coverages available; or only the following coverage:  
 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: 0970-0222 OMB Expiration Date: 11/30/2025.**

**LIMITATIONS ON WITHHOLDING**

The total amount withheld for both cash and medical support cannot exceed \_\_\_\_\_% 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: \_\_\_\_\_.

**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> .

**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: \_\_\_\_\_

2. Reason for termination of order/notice: \_\_\_\_\_

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

Last, First, Middle Name of Child(ren):

DOB:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

**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:

Address line 1: \_\_\_\_\_

Address line 2: \_\_\_\_\_

Address line 3: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Zip Code Extn: \_\_\_\_\_

\_\_\_\_\_

(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 3<sup>rd</sup> 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  
\_\_\_\_\_

Contact Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Email: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
FAX: \_\_\_\_\_  
FEIN: \_\_\_\_\_

Contact Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Email: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
FAX: \_\_\_\_\_  
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](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, telephone number or email 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, telephone number or email listed on page 1 of this Notice.

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