

PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT:	CASE NUMBER:
EMPLOYER'S HEALTH INSURANCE RETURN	

1. Name of parent employee:
 2. Home address of absent parent employee:
 Not known
 3. The employee has *no* insurance policies for health care, vision care, or dental care through this employment.
 4. The employee has the following insurance policies covering health care, vision care, and dental care:
- | <u>Company</u> | <u>Type of policy</u> | <u>Policy No.</u> | <u>Persons insured</u> |
|----------------|-----------------------|-------------------|------------------------|
|----------------|-----------------------|-------------------|------------------------|

Date: _____

(TYPE OR PRINT NAME OF EMPLOYER)	(SIGNATURE OF EMPLOYER)
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Address: _____

Telephone No.: _____

5. Return this completed return to the following local child support agency within 30 days (*name and address of local child support agency*):

If any insurance coverage lapses, complete the notice below and return a copy to the same local child support agency.

NOTICE OF LAPSE IN HEALTH INSURANCE

6. The health insurance listed on the *Employer's Health Insurance Return* above has
 lapsed terminated **for (check one):**
- a. all persons insured, for the following reason (*specify*):

 - b. the following person (*name*): _____ for the following reason (*specify*):

Date: _____

(TYPE OR PRINT NAME OF EMPLOYER)	(SIGNATURE OF EMPLOYER)
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Address: _____

Telephone No.: _____