

ATTORNEY OR PARTY WITHOUT ATTORNEY <i>(Name, State Bar number, and address):</i> TELEPHONE NO.: _____ FAX NO. <i>(Optional)</i> : _____ E-MAIL ADDRESS <i>(Optional)</i> : _____ ATTORNEY FOR <i>(Name)</i> : _____	FOR COURT USE ONLY
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT:	
REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT	CASE NUMBER:

NOTICE: If you object to the *Application and Order for Health Insurance Coverage* (form FL-470) or *National Medical Support Notice* (form OMB-0970-0222), complete and file this form with the court clerk to request a hearing. This form may not be used to modify your current child support amount. (See "Information Sheet on Changing a Child Support Order" on page 2 of form FL-192.)

1. A hearing on this application will be held as follows *(see instructions for getting a hearing date on form FL-478-INFO)*:

a.

Date:	Time:	<input type="checkbox"/> Dept.:	<input type="checkbox"/> Div.:	<input type="checkbox"/> Room:
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b. The address of the court is same as above other *(specify)*:

2. I request that service of the *Application and Order for Health Insurance Coverage* (form FL-470) or *National Medical Support Notice* (form OMB-0970-0222) be quashed (set aside) because:
- a. I am not the obligor named in the *Application and Order for Health Insurance Coverage* or *National Medical Support Notice*.
 - b. Health insurance coverage is not available at a reasonable cost.
 - c. The health insurance premium plus the monthly payment in any earnings assignment order are more than half of my total net income each month from all sources.
 - d. The following children *(name)*: _____ are emancipated.
 - e. I was not notified at least 15 days before the date of filing of the application that a health insurance coverage assignment was being sought.
 - f. No order to maintain health insurance has been issued.
 - g. Health insurance coverage is or will be provided for the children, but not through a parent's job-related coverage *(explain)*:
 - h. The employer's choice of coverage is inappropriate *(explain)*:
 - i. Other *(specify)*:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____

_____ (TYPE OR PRINT NAME OF PERSON REQUESTING HEARING)	}	_____ (SIGNATURE OF PERSON REQUESTING HEARING)
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PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT:	CASE NUMBER:
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NOTICE FOR CASES INVOLVING A LOCAL CHILD SUPPORT AGENCY

This case may be referred to a court commissioner for hearing. By law, court commissioners do not have the authority to issue final orders and judgments in contested cases unless they are acting as temporary judges. The court commissioner in your case will act as a temporary judge unless, *before the hearing*, you or any other party objects to the commissioner acting as a temporary judge. The court commissioner may still hear your case to make findings and a recommended order. If you do not like the recommended order, you must object to it within 10 court days; otherwise, the recommended order will become a final order of the court. If you object to the recommended order, a judge will make a temporary order and set a new hearing.

CLERK'S CERTIFICATE OF MAILING

I certify that I am not a party to this action and that a true copy of the *Request and Notice of Hearing Regarding Health Insurance Assignment* (form FL-478) was mailed, with postage fully prepaid, in a sealed envelope addressed as shown below, and that the request was mailed at (place): _____ on (date): _____

Date:

Clerk, by _____, Deputy

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Request for Accommodations

Assistive listening systems, computer-assisted real-time captioning, or sign language interpreter services are available if you ask at least five days before the proceeding. Contact the clerk's office or go to www.courtinfo.ca.gov/forms for *Request for Accommodations by Persons With Disabilities and Response* (form MC-410). (Civil Code, § 54.8)