COHI

GENESEE COUNTY FRIEND OF THE COURT
HEALTH INSURANCE COMPLAINT FORM

CASE NUMBER:_____ **PARALEGAL**:_____
CASEWORKER:_____
YOUR NAME: _____ **TELEPHONE**: _____
ADDRESS: _____ **WORK**: _____
_____ **CELL: _____**

SOCIAL SECURITY NUMBER: _____

COMPLAINT AGAINST:_____ Alias:_____

Address: _____ City/State/Zip_____

Physical attributes: Height_____ Weight_____ Race_____ Hair_____ Eyes_____ Gender M/F

Tattoos/Distinguishing Marks_____

Telephone: Daytime_____ Work_____ Cell_____

HEALTH INSURANCE COMPLAINT – CHECK ALL THAT APPLY

☐ I do not have a health ID card for the minor child(ren). (medical, dental, optical, prescription).

☐ The child(ren) receive Medicaid however my employer received notice from FOC to add the child(ren) to my health insurance plan and I can not afford it. (My employer's name and fax is:_____.)

☐ My health insurance premiums exceed 5% of my gross income. (Proof of my income and health insurance costs are attached as required. My employer's name and fax number is: _____.)

☐ My current spouse provides health insurance for my minor child(ren); however my employer received a Notice to Withhold for healthcare coverage. (If you check this box you must provide a copy of the health ID cards. The Employers name and fax number is _____.)

☐ Pursuant to the court order, I am not responsible for obtaining/maintaining health insurance for the minor child (ren). (The name and fax number for my employer is _____.)

☐ The minor child(ren) already has/have health care coverage through _____. Please provide a copy of the health insurance card and provide the name and fax number of your Employer _____.

☐ I am a 3rd party and have no legal obligation to provide health insurance for the minor child(ren). (Please provide the name and fax number for your employer _____.)

☐ The opposing party has failed to provide medical insurance for the minor child(ren). ***IF the other party does not have insurance available through his/her employer or is not employed, the health insurance provision of the court order may not be enforced.***

☐ OTHER: Please state the violation of the court order regarding health insurance:

_____

_____

_____

COMPLAINANT'S SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Complaint taken by_____

Above address of complainant same as MICSES_____

Change to above address also submitted by complainant_____