# 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 enforce against the Custodial Parent.

☒ **National Medical Support Order/Notice (NMSN)** ☐ **Termination Order/Notice (Optional)**

| | |
|---|---|
| Issuing Agency:<br>Issuing Agency Address:<br>Medical Support Unit<br>PO Box 15369<br>Albany NY 12212-5369<br>Notice Date:<br>CSE Agency Case Identifier:<br>Telephone Number: **888-208-4485**<br>FAX Number: **518-320-1081** | Court or Administrative Authority:<br><br>Order Date:<br>Order Identifier:<br>Document Tracking Identifier:<br>Employer website: **childsupport.ny.gov**<br>See NMSN Instructions:<br>**http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form** |

RE

Employer/Withholder's Federal EIN Number

Employer/Withholder's Name

Employer/Withholder's Address

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

Custodial Parent's Mailing Address

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

Name and Telephone of Representative of the Child(ren)

Employee's Name (Last, First, MI)

Employee's Social Security Number

Employee's Mailing Address

Substituted Official/Agency Name

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

Mailing Address of a Representative of the Child(ren)

| Child(ren)'s Name(s) | Gender | DOB | SSN | Rec. No. |
|---|---|---|---|---|
| | | | | |
| | | | | |

The order requires the child(ren) to be enrolled in ☒ all health coverages available; or only the following coverage(s): ☐ Medical; ☐ Dental; ☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐ Other (specify):

**LIMITATIONS ON WITHHOLDING**

The total amount withheld for both cash and medical support cannot exceed 50-55% 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 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 4, 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: deductions to satisfy current support obligations shall have priority over deductions for the employee's share of health insurance premiums which shall have priority over any additional deduction for support arrears authorized by subdivision (g) of section 5241 of NYS Civil Practice Law and Rules.

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As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

**Additional Information for Termination Order/Notice (Optional)**

1. **Effective date of medical support termination:** _____
2. **Reason for termination:** _____
3. **Child(ren) to be terminated:**

| **Child(ren)'s Name(s) (Last, First, Middle)** | **DOB** |
|---|---|
| _____ | |
| _____ | |
| _____ | |

## 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 not employed by employer:

Effective date of termination: _____

Reason for 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: _____ FAX Number: _____
Contact Person: _____ Telephone Number: _____
Employer Name: _____ Telephone Number: _____
Employer Representative Name/Title: _____ Federal EIN: _____
(if not provided on Page 1 of this Notice)
Employee Name: _____ Date: _____

| New York Case Identifier: | County Code: | JRE No: | Worker Code: |
|---|---|---|---|

## 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 – Employer Response**. 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 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 OTHER ACTION IS NECESSARY.
2. If family 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 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

      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.

   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** 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.

3. If the Termination Order/Notice (Optional) checkbox is checked, you are required to terminate the health care coverage for the child(ren) identified in the order unless the employee has indicated that they want to continue coverage voluntarily.

**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 the 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 1 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:<br>Issuing Agency Address:<br>Medical Support Unit<br>PO Box 15369<br>Albany NY 12212-5369<br>Notice Date:<br>CSE Agency Case Identifier:<br>Telephone Number: **888-208-4485**<br>FAX Number: **518-320-1081** | Court or Administrative Authority:<br><br>Order Date:<br>Order Identifier:<br>Document Tracking Identifier:<br>Employer web site: **childsupport.ny.gov**<br>See NMSN Instructions:<br>**http://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

_____
Substituted Official/Agency 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 | Rec. No. |
|---|---|---|---|---|
| | | | | |
| | | | | |

The order requires the child(ren) to be enrolled in ☒ all health coverages available; or only the following coverage(s):
☐ Medical; ☐ Dental; ☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐ Other (specify):
_____

# 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)

Case # _____(to be completed by the issuing agency)

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: _____ _____
No. Street or PO Box City State Zip

| New York Case Identifier: | County Code: | JRE No: | Worker Code: |
|---|---|---|---|

# 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 of 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. You may choose to furnish these notifications electronically in

accordance with the requirements of the Department of Labor's electronic disclosure regulation codified at 29 C.F.R. 2520.104b-1(c).

**UNLAWFUL REFUSAL TO ENROLL**

Enrollment of a child may not be denied on the grounds 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 Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provision of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately 20 minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0113. Expiration Date: 10/31/2022.

**Date:**
**MEDICAL SUPPORT UNIT**
**PO BOX 15369**
**ALBANY NY 12212-5369**

# PLAN ADMINISTRATOR RESPONSE ADDENDUM

**New York Case Identifier:**
**Worker Code:**
**Employee Name:**
**Employee SSN:**

Dear Plan Administrator:

Please complete this form to provide specific information to verify the enrollment of employee children covered under the group plan. Return this completed form along with **PART B – MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR** to:

Medical Support Unit
PO Box 15369
Albany NY 12212-5369

**EMPLOYEE INFORMATION:**
Name:
SSN:
Address:

**EMPLOYER INFORMATION:**
Name:
EIN:
Address:

1. The participant is subject to a waiting period that expires* ____/____/____ (more than 90 days from the date of receipt of the Notice), or has not completed a waiting period 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 end of the waiting period, the plan administrator must process the enrollment.

2. Indicate **by placing a ✓ in the "yes" or "no" box** if the employee's dependent(s) listed is/are enrolled under the group health care coverage plan.

| Child(ren)'s Name(s) | Date of Birth | Social Security Number | Record No. | YES | NO |
|---|---|---|---|---|---|
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

3. Using the list on the reverse side of this form, enter the code for the type of coverage provided under each plan in the boxes (e.g. MM = Major Medical). Also enter the name(s) and claims address for each group plan carrier in which the employee dependent(s) listed above is/are now enrolled.

**TYPE OF COVERAGE**

**Code(s)**

**Group Ins. Carrier #1:** _____ **NYS INS CD** _____

**Claims address:** _____

_____

**Policyholder ID No.** _____ **Group No.** _____ **Effective Date:** / /

**Code(s)**

**Group Ins. Carrier #2:** _____ **NYS INS CD** _____

**Claims address:** _____

_____

**Policyholder ID No.** _____ **Group No.** _____ **Effective Date:** / /

**Code(s)**

**Group Ins. Carrier #3:** _____ **NYS INS CD** _____

**Claims address:** _____

_____

**Policyholder ID No.** _____ **Group No.** _____ **Effective Date:** / /

**Code(s)**

**Group Ins. Carrier #4:** _____ **NYS INS CD** _____

**Claims address:** _____

_____

**Policyholder ID No.** _____ **Group No.** _____ **Effective Date:** / /

**Code:**

**Group Ins. Carrier #5:** _____ **NYS INS CD** _____

**Claims address:** _____

_____

**Policyholder ID No.** _____ **Group No.** _____ **Effective Date:** / /

| CODE | COVERAGE TYPES | CODE | | CODE | |
|---|---|---|---|---|---|
| [illegible] | Clinic | ER | Emergency Room | PO | Physician in-office |
| CM | Complement to Medicare | HH | Home Health | PI | Psychiatric in-patient |
| DN | [illegible] | IP | In-Patient | PS | Psychiatric out-patient |
| [illegible] | Drugs (Major Medical) | MM | Major Medical | SI | Substance abuse in-patient |
| DR | Drugs (no card provided) | NH | Nursing Home | SO | Substance abuse out-patient |
| DC | Drugs (with co-pay) | OP | Optical | TR | Transportation |
| EQ | Durable medical equipment | PH | Physician in-hospital | | |

**Completed By:** _____ **Title:** _____

**Phone Number:** _____ **Date:** _____

| New York Case Identifier: | County Code: | JRE No: | Worker Code: |
|---|---|---|---|