

**GENESEE COUNTY FRIEND OF THE COURT  
HEALTH INSURANCE AND/OR  
UNINSURED MEDICAL BILLS REIMBURSEMENT COMPLAINT FORM**

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**CASE NUMBER:** \_\_\_\_\_

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

**YOUR NAME:** \_\_\_\_\_

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

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

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

\_\_\_\_\_

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

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

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_

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

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DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Complaint taken by \_\_\_\_\_

Above address of complainant same as MICES \_\_\_\_\_

Change to above address also submitted by complainant \_\_\_\_\_

