

**GENESEE COUNTY FRIEND OF THE COURT  
HEALTH INSURANCE COMPLAINT FORM**

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

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

**PLEASE PRINT CLEARLY**

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

YOUR NAME: \_\_\_\_\_ CURRENT ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_ S.S. NO.: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

RACE: \_\_\_\_\_ SEX: \_\_\_\_\_ DRIVER LIC. NO. & STATE: \_\_\_\_\_ PLACE OF EMPLOYMENT & ADDRESS: \_\_\_\_\_

OPPOSING PARTY: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_ S.S. NO. : \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

RACE: \_\_\_\_\_ SEX: \_\_\_\_\_ DRIVER LIC. NO. & STATE: \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ HAIR COLOR \_\_\_\_\_

EYE COLOR: \_\_\_\_\_ ANY DISTINGUISHING MARKS: \_\_\_\_\_

PLACE OF EMPLOYMENT & ADDRESS \_\_\_\_\_

**CHILDREN INVOLVED IN THIS CASE**

NAME(S): \_\_\_\_\_ SEX: \_\_\_\_\_ BIRTH DATE(S): \_\_\_\_\_ RACE: \_\_\_\_\_ S.S. NO.(S): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HEALTH INSURANCE COMPLAINT (PLEASE CHECK ALL THAT APPLY)**

I don't have a health ID card for the minor child(ren). (i.e., medical, dental, optical, prescription).

The dependent child(ren) receive Medicaid benefits. However, my employer received a notice from the Friend of the Court to add the minor child(ren) onto my health insurance plan and I can't afford it. **(Please provide the fax number for your employer: \_\_\_\_\_)**

**CONTINUE ON REVERSE SIDE**

COMPLAINT TAKEN BY  
ABOVE ADDRESS OF COMPLAINANT SAME AS MICSES SYSTEM \_\_\_\_\_

CHANGE TO ABOVE ADDRESS ALSO SUBMITTED BY THE COMPLAINANT \_\_\_\_\_

- My health insurance premiums exceed 5% of my gross income. **If you check this box, you must provide our office with a copy of your earnings and proof of your health insurance costs before you submit this complaint. You may obtain a statement from your employer that verifies how much your health insurance deductions are. Please provide the fax number for your employer: \_\_\_\_\_.**
  
- The opposing party has failed to provide the dependent child(ren) with health insurance through his/her employer.
  
- My current spouse provides health insurance for my minor child(ren). However, my employer received a Notice to Withhold for healthcare coverage. Please stop this action since the child(ren) is/are already covered. **If you check this box, you must provide our office with a copy of the health ID cards. Please provide the fax number for your employer: \_\_\_\_\_.**
  
- Pursuant to my court order, I am not responsible for obtaining/maintaining health insurance for my minor child(ren). **Please provide the fax number for your employer: \_\_\_\_\_.**
  
- The minor child(ren) already has/have health care coverage provided through \_\_\_\_\_.  
**Please provide a copy of the health insurance card and provide the fax number for your employer: \_\_\_\_\_.**
  
- I am a 3<sup>rd</sup> party and I have no legal obligation to provide health insurance for the minor child(ren) on this case. **Please provide the fax number for your employer: \_\_\_\_\_.**
  
- The opposite party has failed to provide medical insurance for the minor child(ren). **Please keep in mind that if the other party does not have an employer, there is a strong possibility that health insurance cannot be enforced.**
  
- Other (Please state the nature of your complaint)

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COMPLAINANT'S SIGNATURE DATE