STATE OF MICHIGAN 16TH JUDICIAL CIRCUIT INGHAM COUNTY	NOTICE OF NONCOMPLIANCE (HEALTH CARE COVERAGE)	CASE NO. 2018-333333-DS HON. TRACEY A YOKKIH

Ingham County Friend of the Court Address:
10 North Main St Lansing, MI 48888

Telephone No. (517) 555-5555
Fax No. (517) 555-1111

Plaintiff's name, address, and telephone no. JANE JEAN DOE 311 Hoover Rd Apt 30 Lansing, MI 48888 (517) 222-1717	v	Defendant's name, address, and telephone no. JOHN JAMES DOE SR 82 Schaf Highway Lansing, MI 48888 (517) 555-1212
Plaintiff's attorney name, address, telephone no., and bar no.		Defendant's attorney name, address, telephone no., and bar no.

1. Date of mailing: July 29, 2020
2. The Office of the Friend of the Court has reviewed your files and determined that you, as [ ] plaintiff, [X] defendant, have failed to obtain or maintain dependent health care coverage that is accessible to the child(ren) and available at a reasonable cost as ordered by the court.
3. **Within 14 days after this notice is mailed, you must complete either the "Proof of Health Care Coverage" or the "Request for Hearing" below and send it to the Friend of the Court.**
4. **Your order allows you to provide public health care coverage for the child(ren) on this case**. For federal public health care coverage information, contact the Federal Marketplace at 800-318-2596 or www.healthcare.gov. For state public health care coverage information, contact the Michigan Health Care Help Line at 855-789-5610 or www.michigan.gov/healthymiplan. For local public health care coverage information, dial 211 or visit www.mi211.org.
5. If you do not respond as required, the Friend of the Court office will notify your employer to deduct premiums for dependent health care coverage and will notify the insurer or plan administrator to enroll the child in dependent health coverage.
6. The order for dependent health care coverage will be applied to current and subsequent employers and periods of employment.

[ ] Check this box if you have proof of health care coverage. Then: 1) complete this proof; and 2) photocopy your insurance card(s) and attach them to this proof. Return this proof and any attachments to the Friend of the Court.

PROOF OF HEALTH CARE COVERAGE

Medical insurance company name and address	Group/Policy/Contract number	Beginning date, if known	Name of policy holder
Medical insurance company name and address	Group/Policy/Contract number	Beginning date, if known	Name of policy holder
Medical insurance company name and address	Group/Policy/Contract number	Beginning date, if known	Name of policy holder

Individuals currently covered by your insurance

Name	Birthdate	Relationship	Medical (check)	Dental (check)	Optical (check)

Date

Signature

[ ] Check this box if you want to request a hearing. Then date and sign the request and return it to the Friend of the Court.

REQUEST FOR HEARING

[ ] I request a hearing to show that health care coverage is not available at a reasonable cost.

[ ] I request a hearing to show that health care coverage is not accessible to the child(ren) because the parent(s) must travel too far to obtain health care services for the child(ren).

____________________ Date

______________________________ Signature