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Rec\_Addr\_CSZ

September 5, 2024

Katie Hobbs  
GovernorAngie Rodgers  
Director

Si usted necesita asistencia con la traducción de este documento, por favor llame a la oficina y pregunte por un representante que hable español.

Employee/Obligor: NCP\_NAME\_FULL  
AZCARES No: CAS\_ID\_CASE  
Employee/Obligor SSN: NCP\_SSN\_PERSON

### Notice To Employer

Pursuant to A.R.S. § 25-535, authority is given to the Division of Child Support Services (DCSS) to issue a National Medical Support Notice for the purposes of obtaining medical coverage for the children of the employee/obligor named above.

- ( ) On , the National Medical Support Notice was forwarded to you. The instructions accompanying this notice requested that you take a specific action, 1) respond to the DCSS by returning Part A, or 2) return Part A to the DCSS and forward Part B to your Plan Administrator. Our records indicate that we have not received the required response from you within the requested timeframe.
- ( ) More than 45 days have passed since the DCSS sent the National Medical Support Notice. We have not received confirmation of medical coverage enrollment. Please return the completed Part "B" of the National Medical Support Notice to the DCSS immediately. Contact the DCSS directly if there will be a delay in returning this form.

Please provide the information requested below and return this letter, within 10 business days, to the office listed in the return address.



- ( ) 1. Employer does not maintain or contribute to plans providing dependent or family health care coverage.
- ( ) 2. 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.
- ( ) 3. Health care coverage is not available because this company no longer employs the employee referenced above.

Date of Termination: \_\_\_\_\_

Last known address: \_\_\_\_\_

Last known telephone number: \_\_\_\_\_

New employer (if known): \_\_\_\_\_

Address: \_\_\_\_\_

- ( ) 4. 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.
- ( ) 5. Part B was forwarded to the Plan Administrator on: \_\_\_\_\_

Name/Address of Plan Administrator: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone # of Plan Administrator: \_\_\_\_\_

- ( ) 6. Date our office or the Support Recipient can expect to receive confirmation of health coverage: \_\_\_\_\_
- ( ) 7. Reason why information/confirmation of health coverage/enrollment has been delayed:

\_\_\_\_\_  
\_\_\_\_\_

If you have any questions about this notice, you may contact DCSS Customer Service at (602) 252-4045 (within Maricopa County), Nationwide toll free at 1-800-882-4151, or TTY/TDD Services: 7-1-1. You may also contact us by e-mail at the DCSS web site at [www.azdes.gov/dcss](http://www.azdes.gov/dcss).

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Child Support Services at (602) 252-4045; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local.

