

ATTORNEY OR PARTY WITHOUT ATTORNEY ( <i>Name, State Bar number, and address</i> ):  <hr/>  TELEPHONE NO.: _____ FAX NO. ( <i>Optional</i> ): _____ E-MAIL ADDRESS ( <i>Optional</i> ): _____ ATTORNEY FOR ( <i>Name</i> ): _____	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF</b> STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
<b>MARRIAGE OF</b> PETITIONER:  RESPONDENT:	
<b>APPLICATION AND ORDER FOR HEALTH INSURANCE COVERAGE</b>	CASE NUMBER:

**APPLICATION**

1. On (*date*): \_\_\_\_\_, this court ordered obligor (*name*): \_\_\_\_\_ to provide health insurance coverage for the children named in the order below.
2. a.  On (*date*): \_\_\_\_\_, which is at least 15 days before the filing of this application, I gave written notice to obligor of my intent to seek this order below  by first-class mail  by personal service.
- OR**
- b.  Obligor has waived the requirement of written notice.
3. I ask the court to order the employer or other person providing health insurance coverage to enroll or maintain the children in any health insurance coverage available to the obligor.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

_____ (TYPE OR PRINT NAME)		_____ (SIGNATURE OF APPLICANT)
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**ORDER FOR HEALTH INSURANCE COVERAGE (ASSIGNMENT)**

**To employer or other person providing health insurance coverage for obligor (name):**  
**Social security number (if known):**

**YOU ARE ORDERED TO**

1. Begin or maintain health insurance coverage of:  

<u>Name of child</u>	<u>Date of birth</u>	<u>Social security No.</u>
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- You may deduct any premium or costs from the wages or earnings of obligor.
2. If the obligor works for you or if you provide health insurance coverage to obligor, give him or her a copy of this order within 10 days after you receive it.
  3. If no health insurance coverage is available to the obligor, complete and sign the *Declaration of No Health Insurance Coverage* on the reverse and mail this form within 20 days to the attorney or person requesting the assignment.

Date:

\_\_\_\_\_  
(JUDICIAL OFFICER)

MARRIAGE OF ( <i>Last name, first name of each party</i> ):  _____	CASE NUMBER:  _____
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### DECLARATION OF NO HEALTH INSURANCE COVERAGE

No health insurance coverage is available to the obligor (*name*):  
because (*state reasons*):

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

\_\_\_\_\_  
(TYPE OR PRINT NAME AND TITLE)



\_\_\_\_\_  
(SIGNATURE OF EMPLOYER OR PERSON PROVIDING HEALTH INSURANCE)

MAIL A COPY OF THIS DECLARATION WITHIN 20 DAYS TO THE ATTORNEY OR PERSON SEEKING THIS ENROLLMENT  
(SEE INSTRUCTION NO. 5, BELOW).

### INSTRUCTIONS FOR EMPLOYER OR OTHER PERSON PROVIDING HEALTH INSURANCE

These instructions apply only to an *Order for Health Insurance Coverage* issued by a court.

1. If the obligor works for you or is covered by health insurance provided by you, you must give him or her a copy of this order within 10 days after you receive it.
2. Unless you receive a motion to quash the assignment, you must take steps to begin or maintain coverage of the specified children within 30 days after you deliver a copy of this order to the obligor. The coverage should begin at the earliest possible time consistent with group plan enrollment rules.
3. The obligor's existing health coverage will be replaced only if the children are not provided benefits under the existing coverage where they reside.
4. If the obligor is not enrolled in a plan and there is a choice of several plans, you may enroll the children in any plan that will reasonably provide benefits or coverage where they live, unless the court has ordered coverage by a specific plan.
5. If no coverage is available, complete the *Declaration of No Health Insurance Coverage* at the top of this page and mail the declaration by first-class mail to the attorney or person seeking the assignment within 20 days of your receipt of this order. Keep a copy of the form for your records.
6. If coverage is provided, you must supply evidence of coverage to both parents and to any person having custody of the child.
7. Upon request of the parents or person having custody of the child, you must provide all forms and other documentation necessary for submitting claims to the insurance carrier to the extent you provide them to other covered individuals.
8. You must notify the applicant of the effective date of the coverage of the children.
9. You will be liable for any amounts incurred for health care services that otherwise would have been covered under the insurance policy if you willfully fail to comply with this order. You can also be held in contempt of court. California law forbids your firing or taking any disciplinary action against any employee because of this order.

### EMPLOYEE INFORMATION

1. This order tells your employer or other person providing health insurance coverage to you to enroll or maintain the named children in a health insurance plan available to you and to deduct the appropriate premium or costs, if any, from your wages or other compensation.
2. You have 15 days after you receive a copy of this order to object to the order. Family Code section 3765 tells you how.
3. Family Code section 3770 tells you how and when to petition the court to end this assignment.