

COURT OF COMMON PLEAS  
DIVISION OF DOMESTIC RELATIONS  
HAMILTON COUNTY, OHIO

Enter \_\_\_\_\_  
Judge

Date \_\_\_\_\_

Case No. \_\_\_\_\_

File No. \_\_\_\_\_

CSEA No. \_\_\_\_\_

Judge \_\_\_\_\_

**QUALIFIED MEDICAL CHILD SUPPORT ORDER**  
**(O.R.C. 3119.30)**

\_\_\_\_\_  
Plaintiff / Petitioner ( ) Obligor ( ) Obligee

-vs-

\_\_\_\_\_  
Defendant / Petitioner ( ) Obligor ( ) Obligee

HEALTH INSURANCE  
PLAN: \_\_\_\_\_

PARTICIPANT 1:  
NAME: \_\_\_\_\_  
Obligor/Obligee

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PARTICIPANT 1:  
EMPLOYER: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

HEALTH INSURANCE PLAN: (If applicable):  
\_\_\_\_\_

PARTICIPANT 2: EMPLOYER:  
\_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ALTERNATE Name(s):  
\_\_\_\_\_

RECIPIENT(S): and DOB  
(Child/ren) \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

WHEREAS, the Court finds that health insurance coverage for the child(ren) named as Alternate Recipient(s) is available to the Participant at a reasonable cost and that the Participant has been ordered to secure/maintain health insurance coverage for the child(ren).

IT IS HEREBY ORDERED THAT:

1. The following group health insurance and health care policies, contracts and plans are available at a reasonable cost to the Participants (include name of insurer that issues each policy, contract or plan):

2. Participant shall provide the insurer within thirty (30) days from the date of this order with a copy of this Order and promptly shall complete the necessary enrollment forms or other documents necessary to designate the Alternate Recipient(s) listed above as dependents eligible for coverage by the Health Insurance Plan identified above in the form and to the same extent coverage is available to the Participant and other dependents of the Participant in the Health Insurance Plan. Participant shall also within thirty (30) days of the issuance of this order, furnish written proof to the Hamilton County Child Support Enforcement Agency, 222 E. Central Pkwy Cincinnati, Ohio that the coverage has been obtained, that the insurer has been provided with a copy of this order, and that the other party has been provided with all documents/information as set forth in paragraph 3 below.

3. Participant shall supply the other party with (a) insurance forms necessary to receive payment. Reimbursement or other benefits; (b) necessary insurance cards; and (c) information regarding the benefits, limitations and exclusions of the coverage of the Health Insurance Plan or any successor plan.

4. Obligor/Obligee shall be responsible for the first \$100.00 per calendar year, per child for all uninsured medical, dental, hospital, prescription, optical, psychological, psychiatric and orthodontic expenses, including co-payments and deductibles (designated "ordinary"). The remaining uninsured expenses (designated "extraordinary"), including additional co-payments and/or deductibles under the Health Insurance Plan for the Alternate Recipient(s), shall be shared by the parties as follows: Obligor - 50% and Obligee - 50% or other agreement or order: \_\_\_\_\_

5. Any reimbursements for out-of-pocket medical, optical, hospital, dental, prescription or other reimbursable expenses covered under the Health Insurance Plan or any successor plan and paid for on behalf of the Alternate Recipient(s) insured child(ren) shall be made directly to: Obligor/Obligee: Name: \_\_\_\_\_ Address: \_\_\_\_\_

The insurer may continue to make payments for medical, optical, hospital, dental or prescription services directly to any health care provider in accordance with the Health Insurance Plan.

6. Participant shall be responsible for any premiums charged by the insurer for coverage of the Alternate Recipient(s) under the Health Insurance Plan.

7. Pursuant to O.R.C. 3119.30, this order is binding upon the Obligor and Obligee, their employers, and any insurer that provides health insurance for them or their child(ren).

8. If Participant fails to provide health insurance coverage for the child(ren) within thirty (30) days as ordered or otherwise to comply within thirty (30) days with any other provision of this Order, the CSEA shall notify the Court in writing of the failure to comply and the Court shall issue an order to the employer to take whatever action is necessary to make application to enroll Participant in any available group health insurance policy or health care policy with coverage for the child(ren) who are subject of the child support order, to submit a copy of this Order for health insurance coverage to the insurer at the time that the employer makes application to enroll the child(ren) in the health insurance or health care policy contract or plan, and if the application is accepted, to deduct any additional amount from earnings necessary to pay the additional cost for that health insurance coverage.

9. Any insurer who receives a copy of an order issued under O.R.C. 3119.30 shall comply with that section, and any order issued under that section, regardless of the residence of the child(ren).

10. During the time that this Order is in effect, the employer who is the subject of the Order upon written request shall release to the other party and the CSEA all information about the health insurance coverage of the Participant, including, but not limited to, the name and address of the insurer and any policy, plan, or contract number.

11. During the time that this Order is in effect, the employer shall notify the CSEA of any change in and/or the termination of the coverage under the Health Insurance Plan.

12. The parties shall notify the Plan Administrator of any change of address of the Participant, Alternate Recipient(s), or the person designated to receive reimbursements as well as any change in status of any Alternate Recipient that would cause him or her to no longer be eligible to receive reimbursements.

13. It is the intention of the parties that this Order continue to qualify as a Qualified Medical Child Support Order under ERISA Section 609, as it may be amended from time to time, and that the Plan Administrator shall reserve the right to reconfirm the qualified status of the Order as benefits become payable hereunder.

14. This Order shall not be construed so as to require the Health Insurance Plan to provide any type or form of benefit, or any option, which otherwise would not be provided to a dependent under the Plan.

15. This Order shall remain in effect until the earliest of: (a) the date that Participant loses his/her employer-sponsored health coverage as a result of his/her termination of employment, retirement, or death/ or (b) the date that the Alternate Recipient is no longer legally ordered to receive child support on his or her behalf; or (c) the date that the employer no longer offers dependent health care coverage to any of its employees under the Health Insurance Plan or any successor plan.

16. If the person required to obtain private health care insurance coverage for the children subject to this child support order obtains new employment, the agency shall comply with the requirements of section 3119.34 of the Revised Code, which may result in the issuance of a notice requiring the new employer to take whatever action is necessary to enroll the children in private health care insurance coverage provided by the new employer.

17. Upon receipt of a notice by the child support enforcement agency that private health insurance coverage is not available at a reasonable cost, cash medical support shall be paid in the amount as determined by the child support computation worksheets in section 3119.022(3119.02.2) or 3119.023 (3119.02.3) of the Revised Code, as applicable. The child support enforcement agency may change the financial obligations of the parties to pay child support in accordance with the terms of the court or administrative order and cash medical support without a hearing or additional notice to the parties.

HAVE SEEN AND APPROVED:

\_\_\_\_\_  
Plaintiff/Petitioner/Obligor/Obligee

\_\_\_\_\_  
Defendant/Petitioner/Obligor/Obligee

\_\_\_\_\_  
Attorney for Plaintiff/Petitioner

\_\_\_\_\_  
Attorney for Defendant/Petitioner

\_\_\_\_\_  
Accepted by Plan Committee or Administrator

\_\_\_\_\_  
Date

**INSTRUCTIONS TO THE CLERK:** You are directed to mail a copy of this Order to the employer and to the Obligor and Obligee by Ordinary Mail, with proof of mailing, unless they have acknowledged receipt by signature above.

**ATTENTION - COPY INSTRUCTIONS:**

You are responsible for the appropriate number of copies: For one participant you need 1 original plus 4 copies; for two participants you need 1 original plus 6 copies. Required number of copies to be submitted along with the original.

**NOTIFICATION**

TO THE OBLIGOR/OBLIGEE:

Obligor/Obligee is required to maintain health care coverage for the minor child(ren) at a reasonable cost through a group health insurance or health care policy, contract or plan offered by his/her employer or through any other available source. It is important for the well-being of your child(ren) that the best (and reasonable) health care coverage be maintained.

Complete this document as appropriate immediately after the occurrence of any of the events listed and mail the original of this document to the office and address listed below.

TO: Hamilton County Child Support Enforcement Agency  
222 E. Central Pkwy  
Cincinnati, Ohio 45202

\_\_\_\_\_ 1. My employer (or new employer) now offers health care coverage for the minor child(ren) effective \_\_\_\_\_, 20\_\_\_\_.

Employer's name and address is: \_\_\_\_\_

Insurer's name, address, policy number, employee cost to cover child(ren) is: \_\_\_\_\_

\_\_\_\_\_ 2. I now have health care coverage available to the child(ren) from another source. State source, address, insurer, insurer's address, policy number and cost to cover child(ren).

Date: \_\_\_\_\_

Case No. \_\_\_\_\_

File No. \_\_\_\_\_

CSEA NO. \_\_\_\_\_

\_\_\_\_\_  
**Obligor's Signature**

\_\_\_\_\_  
Address

\_\_\_\_\_  
 Check here if new address

\_\_\_\_\_  
Daytime Phone No. \_\_\_\_\_

\_\_\_\_\_  
**Obligee's Signature**

\_\_\_\_\_  
Address

\_\_\_\_\_  
 Check here if new address

\_\_\_\_\_  
Daytime Phone No. \_\_\_\_\_