DISENROLLMENT OF DEPENDENT CHILD UNDER EXISTING QUALIFIED MEDICAL CHILD SUPPORT ORDER FORM

(TO BE COMPLETED BY PLAN ADMINISTRATOR FOR GROUP)

The Plan Administrator for the group health plan identified below has previously determined that the attached medical child support order, dated , constitutes a Qualified Medical Child Support Order ("QMCSO") as defined under Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended, or Section 1908 of Title XIX of the Social Security Act. Effective , the Plan Administrator hereby directs that coverage for the following child(ren) be eliminated.

As set forth in the attached Qualified Medical Child Support Order Certification Form, dated , and as required under Section 5241(b)(3) of the New York CPLR, an employer may not legally disenroll or eliminate the health coverage of a child under a QMCSO unless the employer has provided satisfactory written evidence that there is a statutory basis for the elimination of such coverage.

The basis for elimination of coverage for the child(ren) is [*check one*];

☐ The QMCSO is no longer in effect as of . The reason and specific provision of the QMCSO which authorizes the elimination of coverage are: .

- If the authority to eliminate coverage is due to a subsequent order, attach a copy of such order.
- If coverage is being provided under a National Medical Support Notice, attach written authorization from the issuing governmental agency to eliminate coverage.

☐ The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of the disenrollment from the group health plan. Attach proof that the child(ren) is or will be enrolled in comparable coverage as of the date of the requested elimination of coverage.

☐ The employer has eliminated family health coverage for all of similarly situated employees. Attach proof of the elimination of such coverage.

☐ Continuation coverage for the child(ren) (e.g., COBRA coverage or continuation coverage available under state law) was not elected, or the period of such coverage has expired. Attach proof that either continuation coverage was not elected or that the elected continuation period has expired.

DELETE COVERAGE FOR THE FOLLOWING CHILD(REN):

LAST NAME (IF DIFF.)	FIRST NAME	DATE OF BIRTH			RELATIONSHIP		IF STUDENT, NAME OF SCHOOL	# CREDIT HOURS	GRADUATION DATE	IS MEMBER DISABLED?	CHECK BOXES IF MEMBER HAS MEDICARE
		MO	DAY	YR	SON	DAU					FEDERAL MEDICARE CLAIM NUMBER ☐ PART A EFF. DATE ☐ PART B EFF. DATE

GROUP HEALTH PLAN INFORMATION

EMPLOYEE/SUBSCRIBER NAME: ID#:

EMPLOYEE/SUBSCRIBER ADDRESS:

GROUP NAME: GROUP NUMBER: **DATE**

SIGNATURE OF PLAN ADMINISTRATOR

PRINT NAME: _____