

INFORMATION SHEET AND INSTRUCTIONS FOR REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT

(Do *not* deliver this information sheet to the court clerk.)

Please follow these instructions to complete the *Request and Notice of Hearing Regarding Health Insurance Assignment* (form FL-478) if you do not have an attorney representing you. Your attorney, if you have one, should complete this form. You must file the completed *Request and Notice of Hearing* form and its attachments with the court clerk **within 15 days** after the date your employer gave you a copy of *Application and Order for Health Insurance Coverage* (form FL-470) or *National Medical Support Notice* (form OMB0970-0222). The address of the court clerk is the same as the one shown for the superior court on the health insurance coverage assignment order. You may have to pay a filing fee. If you cannot afford to pay the filing fee, the court may waive it, but you will have to fill out some forms first. For more information about the filing fee and waiver of the filing fee, contact the court clerk or the family law facilitator in your county.

(TYPE OR PRINT IN INK)

Front page, first box, top of form, left side: Print your name, address, and telephone number in this box if they are not already there.

Item 1. a–b. You must contact the court clerk's office and ask that a hearing date be set for this motion. The court clerk will give you the information you need to complete this section.

Item 2. Check this box if you want the court to stop the local child support agency or the other parent from collecting a health insurance premium from your wages or earnings. If you check this box, you must check at least one of the boxes beneath it.

- a. Check this box if you are not the person required to pay health insurance premiums in the *Application and Order for Health Insurance Coverage* or *National Medical Support Notice*.
- b. Check this box if you believe that health insurance coverage is not available at a reasonable cost.
- c. Check this box if you believe the health insurance premium plus the monthly payment in any earnings withholding order are more than half of your total net income each month from all sources.
- d. Check this box if you believe the children have reached the legal age of emancipation. Fill in the children's names.
- e. Check this box if you were not notified at least 15 days before the date of filing of the application that a health insurance coverage assignment was being sought.
- f. Check this box if the court has not ordered you to maintain health insurance.
- g. Check this box if you and the other parent have made other arrangements to provide health care coverage.
- h. Check this box if you believe that your employer's choice of coverage is inappropriate and explain why.
- i. Check this box if you have some other reason that this order should not be enforced and explain why.

You must date this *Request and Notice of Hearing Regarding Health Insurance Assignment*, print your name, and sign the form under penalty of perjury. You must also complete the certificate of mailing on page 2 of the form by printing the name and address of the other parties in brackets and providing a stamped envelope addressed to each of the parties. When you sign this form, you are stating that the information you have provided is true and correct. After you file the request, the court clerk will notify you by mail of the date, time, and location of the hearing.

You must file your request within 15 days of receiving the *Application and Order for Health Insurance Coverage* or *National Medical Support Notice* from your employer. You may file your request in person at the clerk's office or mail it to the clerk. In either event, it must be received by the clerk within the 15-day period.

If you need additional assistance with this form, contact an attorney or the family law facilitator in your county. The family law facilitator can help you, for free, with any questions you have about the above information. For more information on finding a lawyer or family law facilitator, see the California Courts Online Self-Help Center at www.courtinfo.ca.gov/selfhelp.

NOTICE: Use this form to request a hearing only if you object to the *Application and Order for Health Insurance Coverage* (form FL-470) or *National Medical Support Notice* (form OMB0970-0222). This form will *not* modify your current support amount. (See "Information Sheet on Changing a Child Support Order" on page 2 of form FL-192.)