ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address):*	*FOR COURT USE ONLY*
TELEPHONE NO.: FAX NO. *(Optional):* E-MAIL ADDRESS *(Optional):* ATTORNEY FOR *(Name):*	Draft 5 03/02/06 icb Not approved by the Judicial Council
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT:	
REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT	CASE NUMBER:

NOTICE: Complete and file this form with the court clerk 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 may not be used to modify your current child support amount. (See "Information Sheet on Changing a Child Support Order" on page 2 of form FL-192.)

1. A hearing on this application will be held as follows *(see instructions for getting a hearing date on form FL-478-INFO):*

   a. Date: Time: ☐ Dept.: ☐ Div.: ☐ Room:

   b. The address of the court is ☐ same as above ☐ other *(specify):*

2. ☐ I request that service of the *Application and Order for Health Insurance Coverage* (form FL-470) or *National Medical Support Notice* (form OMB0970-0222) be quashed (set aside) because:
   - a. ☐ I am not the obligor named in the *Application and Order for Health Insurance Coverage or National Medical Support Notice.*
   - b. ☐ Health insurance coverage is not available at a reasonable cost.
   - c. ☐ The health insurance premium plus the monthly payment in any earnings assignment order are more than half of my total net income each month from all sources.
   - d. ☐ The following children *(name):* have been emancipated.
   - e. ☐ I was not notified at least 15 days before the date of filing of the application that a health insurance coverage assignment was being sought.
   - f. ☐ No order to maintain health insurance has been issued.
   - g. ☐ The children will be otherwise provided health insurance coverage.
   - h. ☐ The employer's choice of coverage is inappropriate *(explain):*
   - i. ☐ Other *(specify):*

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 OF PERSON REQUESTING HEARING) (SIGNATURE OF PERSON REQUESTING HEARING)

Form Adopted for Mandatory Use
Judicial Council of California
FL-478 [New January 1, 2007]

REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT
(Family Law—Governmental—UIFSA)

Family Code, § 5246
www.courtinfo.ca.gov

PETITIONER/PLAINTIFF:	CASE NUMBER:
RESPONDENT/DEFENDANT:	
OTHER PARENT:	

CLERK'S CERTIFICATE OF MAILING

I certify that I am not a party to this action and that a true copy of the *Request and Notice of Hearing Regarding Health Insurance Assignment* (form FL-478) was mailed, with postage fully prepaid, in a sealed envelope addressed as shown below, and that the request was mailed at *(place):* on *(date):*

Date:

Clerk, by _____, Deputy

Request for Accommodations
Assistive listening systems, computer-assisted real-time captioning, or sign language interpreter services are available if you ask at least five days before the proceeding. Contact the clerk's office or go to *www.courtinfo.ca.gov/forms* for *Request for Accommodations by Persons With Disabilities and Order* (form MC-410). (Civil Code, § 54.8)