

LAKE REGIONAL MEDICAL  
200 SOUTH YORKSHIRE STREET  
SALEM VA 24153

NOTE: THE ATTACHED DOCUMENT CONCERNS A CHILD SUPPORT CASE WITH THE  
VIRGINIA DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

NATIONAL MEDICAL SUPPORT NOTICE - PART A  
NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to enforce against the Custodial Parent.

Issuing Agency:  
ROANOKE DISTRICT OFFICE  
Issuing Agency Address:  
CHILD SUPPORT ENFORCEMENT  
3535 FRANKLIN ROAD SW SUITE H  
ROANOKE VA 24014 2255  
Notice Date: JANUARY 29, 2016  
CSE Agency Case Identifier:  
0004743210  
Telephone Number: 800-468-8894  
FAX Number: 540-857-7841

Court or Administrative Authority:  
ROANOKE COUNTY JDR COURT  
Order Date: 05/28/2014  
Order Identifier: J15808010  
Document Tracking Identifier:  
Employer web site:  
See NMSN Instructions:  
<http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form>

541480585  
Employer/Withholder's Federal EIN Nbr. RE: JENKS, BRIAN PEYTON  
Employer's Name (Last, First, MI)  
LAKE REGIONAL MEDICAL 242-51-7707  
Employer/Withholder's Name Employee's Social Security Number  
200 SOUTH YORKSHIRE STREET 3606 BOND ST  
SALEM VA 24153 ROANOKE VA 24018 2510

Employer/Withholder's Address Employee's Mailing Address  
WHEELER, MARY BETH  
Custodial Parent's Name (Last,First,MI) Substituted Official/Agency Name  
5325 SUGAR LOAF MOUNTAIN RD  
ROANOKE VA 24018 7819

Custodial Parent's Mailing Address Substituted Official/Agency Address  
(Required if Custodial Parent's  
mailing address is left blank)

Child(ren)'s Mailing Address (if  
different from Custodial Parent's )

Name and Telephone of a Representative Mailing Address of a Representative  
of the Child(ren) of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN
WHEELER, ANNABELLA GRACE	F	11/06/2009	691-14-9862

The order requires the child(ren) to be enrolled in (X) all health coverages available; or only the following coverage(s): ( ) Medical; ( ) Dental; ( ) Vision; ( ) Prescription drug; ( ) Mental Health; ( ) Other (specify):

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13). Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. OMB control number: 0970-0222 Expiration Date: 08/31/2016.

#### LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed 65 % of the employee's aggregate disposable weekly earnings. The employer may not withhold more under this National Medical Support Notice than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));
2. The amounts allowed by the State of the employee's principal place of employment; or
3. The amounts allowed for health insurance premiums by the child support order, as indicated here:

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes. As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

#### PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support, as described here: cash support first and medical support contributions second. As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

EMPLOYER RESPONSE

If 1, 2, 3, 4 or 5 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If 1 through 5 does not apply, complete item 7 and forward Part B to the appropriate Plan Administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. This includes any organization or labor union that provides group health care benefits to the employee. Check number 5 and return this Part A to the Issuing Agency if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization. You are required to respond to the Issuing Agency by returning this Employer Response regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization. Information for the Plan Administrator and the Employer Representative at the bottom of this section is required.

- ( ) 1. The employee named in this Notice has never been employed by this employer.
( ) 2. We, the employer, do not offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.
( ) 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.
( ) 4. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: \_\_\_\_\_
Last known telephone number: \_\_\_\_\_
Last known address: \_\_\_\_\_
New employer (if known): \_\_\_\_\_
New employer telephone number: \_\_\_\_\_
New employer address: \_\_\_\_\_

- ( ) 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.
( ) 6. The participant is subject to a waiting period that expires \_\_\_\_\_ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period, which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: \_\_\_\_\_). At the completion of the waiting period, the Plan Administrator will process the enrollment.
( ) 7. Employer forwarded Part B to Plan Administrator on \_\_\_\_\_ MM/DD/YY.

CONTACT FOR QUESTIONS

Plan Administrator Name: \_\_\_\_\_ FAX Number: \_\_\_\_\_
Contact Person: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
Employer Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
Employer Representative Name/Title: \_\_\_\_\_
Federal EIN: \_\_\_\_\_ (if not provided on Page 1 of this Notice)
Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

This document serves as legal notice that the employee identified on this National Medical Support Notice is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified on this Notice. This National Medical Support Notice replaces any Medical Support Notice that the Issuing Agency has previously served on you with respect to the employee and the children listed on this Notice.

The document consists of Part A - Notice to Withhold for Health Care Coverage for the employer to withhold any employee contributions required by the group health plan(s) in which the child(ren) is/are enrolled; and Part B - Medical Support Notice to the Plan Administrator, which must be forwarded to the Administrator of each group health plan identified by the employer to enroll the eligible child(ren), or completed by the employer, if the employer serves as the health Plan Administrator.

An employer receiving this legal Notice is required to complete and return Part A. If group health coverage is not available to the employee named herein, or the employee was never or is no longer employed, the employer is still required to complete Part A - Employer Response and return it to the Issuing Agency with the appropriate response checked. If you, the employer, provide the health care benefits to the employee, forward Part B - Plan Administrator Response to the health Plan Administrator of your organization. If the employee's health care benefits are administered through another organization, including a labor union, forward Part B of the Notice to the labor union or other organization acting as the Plan Administrator for completion. If the employee has already enrolled the child(ren) in health care coverage, the employer must forward Part B to the Plan Administrator for completion and submittal to the Issuing Agency.

Keep a copy of Part A as it may be used to notify the Issuing Agency if the employee separates from service for any reason including retirement or termination.

#### EMPLOYER RESPONSIBILITIES

1. If the individual named in this Notice is not your employee, or if the family health care coverage is not available, please complete item 1, 2, 3, 4, or 5 of the Employer Response as appropriate, and return it to the Issuing Agency. NO OTHER ACTION IS NECESSARY.
2. If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:
  - a. Transfer, not later than 20 business days after the date of this Notice, a copy of Part B - Medical Support Notice to the Plan Administrator to the Administrator of each appropriate group health plan for which the child(ren) may be eligible, complete item 7, and
  - b. Upon notification from the Plan Administrator(s) that the child(ren) is/are enrolled, either
    - 1) withhold from the employee's income any employee contributions required under each group health plan, in accordance with the applicable law of the employee's principal place of employment and transfer employee contributions to the appropriate plan(s), or
    - 2) complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.
  - c. If the Plan Administrator notifies you that the employee is subject to a waiting period that expires more than 90 days from the date of its receipt of Part B of this Notice, or whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete item 6 of the Employer Response to notify the Issuing Agency of the enrollment timeframe and notify the Plan Administrator when the employee is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice in the plan.

## DURATION OF WITHHOLDING

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when conditions for eligibility for coverage under terms of the plan no longer apply. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided satisfactory written evidence that:
  - a. The court or administrative child support order referred to in this Notice is no longer in effect; or
  - b. The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan; or
2. The employer eliminates family health coverage for all of its employees.

## POSSIBLE SANCTIONS

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s) as the Notice directs. Sanctions or penalties may be imposed under State law against an employer for failure to respond and/or for non-compliance with this Notice.

## NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the above employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending to the Issuing Agency a copy of Part A with response 4 checked or any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act.

## EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest the withholding under this Notice based on a mistake of fact (such as the identity of the obligor). Should an employee contest the withholding under this Notice, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. To contest the withholding under this Notice, the employee should contact the Issuing Agency at the address and telephone number listed on the Notice. With respect to plans subject to ERISA, it is the view of the Department of Labor that Federal Courts have jurisdiction if the employee challenges a determination that the Notice constitutes a Qualified Medical Child Support Order.

## CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed at page 1 of this Notice.

VA Code Sections: 63.2-1924  
63.2-1924.1  
63.2-1925  
63.2-1942  
63.2-1944

NATIONAL MEDICAL SUPPORT NOTICE - PART B  
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA) and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive of 1998 (CSPIA). Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to enforce against the Custodial Parent.

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Issuing Agency: ROANOKE DISTRICT OFFICE	Court or Administrative Authority: ROANOKE COUNTY JDR COURT
Issuing Agency Address: CHILD SUPPORT ENFORCEMENT 3595 FRANKLIN ROAD SW SUITE H ROANOKE VA 24014 2255	Order Date: 05/28/2014 Order Identifier: J15808010 Document Tracking Identifier: Employer website:
Notice Date: JANUARY 29, 2016	See NMSN Instructions: <a href="http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form">http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form</a>
CSE Agency Case Identifier: 0004743210	
Telephone Number: 800-468-8894	
FAX Number: 540-857-7841	

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541480585 Employer/Withholder's Federal EIN Nbr.	RE: JENKS, BRIAN PEYTON Employee's Name (Last, First, MI)
LAKE REGIONAL MEDICAL Employer/Withholder's Name	242-51-7707 Employee's Social Security Number
200 SOUTH YORKSHIRE STREET SALEM VA 24153	3606 BOND ST ROANOKE VA 24018 2510

Employer/Withholder's Address	Employee's Mailing Address
WHEELER, MARY BETH Custodial Parent's Name (Last,First,MI)	Substituted Official/Agency Name
5325 SUGAR LOAF MOUNTAIN RD ROANOKE VA 24018 7819	
Custodial Parent's Mailing Address	Substituted Official/Agency Address (Required if Custodial Parent's mailing address is left blank)

Child(ren)'s Mailing Address (if  
different from Custodial Parent's )

Name and Telephone of a Representative of the Child(ren)	Mailing Address of a Representative of the Child(ren)
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Child(ren)'s Name(s) WHEELER, ANNABELLA GRACE	GENDER	DOB	SSN
		11/06/2009	691-14-9862

The order requires the child(ren) to be enrolled in (X) all health coverages available; or only the following coverage(s): ( ) Medical; ( ) Dental; ( ) Vision; ( ) Prescription drug; ( ) Mental Health; ( ) Other (specify):

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THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. OMB control number: 1210-0113 Expiration Date: 03/31/2016.

PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

Case # 0004743210 (to be completed by the issuing agency)

This Notice was received by the plan administrator on \_\_\_/\_\_\_/\_\_\_\_\_ .

- ( ) 1. This Notice was determined to be a "qualified medical child support order," on \_\_\_/\_\_\_/\_\_\_\_\_. Complete Response 2 or 3, and 4, if applicable.
- 2. The participant (employee) and alternate recipients(s) (child(ren)) are to be enrolled in the following family coverage.
  - ( ) a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
  - ( ) b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
  - ( ) c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
  - ( ) d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of \_\_\_/\_\_\_/\_\_\_\_\_ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option (if plan is insured, identify provider, policy and group numbers): \_\_\_\_\_ Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

- ( ) 3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any: \_\_\_\_\_
- ( ) 4. The participant is subject to a waiting period that expires \_\_\_/\_\_\_/\_\_\_\_\_ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: \_\_\_\_\_). At the completion of the waiting period, the plan administrator will process the enrollment.
- ( ) 5. This Notice does not constitute a "qualified medical child support order" because:
  - ( ) The name of the ( ) child(ren) or ( ) participant is unavailable.
  - ( ) The mailing address of the ( ) child(ren) (or substituted official) or ( ) participant is unavailable.
  - ( ) The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan.

\_\_\_\_\_ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Title: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PLAN SELECTION INFORMATION

Employee Name: BRIAN P. JENKS  
Employee SSN: 242-51-7707

Insurance Company: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_  
\*Policy #: \_\_\_\_\_ \*Group #: \_\_\_\_\_  
Coverage Available (Check all that apply):  
\_\_\_ Medical; \_\_\_ Dental; \_\_\_ Vision;  
\_\_\_ Prescription Drug; \_\_\_ Mental Health;  
\_\_\_ Other (specify): \_\_\_\_\_  
Premium Cost/Frequency  
to enroll child(ren): \$ \_\_\_\_\_ per \_\_\_\_\_

DEFAULT OPTIONS AVAILABLE OR ADDITIONAL COVERAGE UNDER SEPARATE POLICY:

Insurance Company: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_  
\*Policy #: \_\_\_\_\_ \*Group #: \_\_\_\_\_  
Coverage Available (Check all that apply):  
\_\_\_ Medical; \_\_\_ Dental; \_\_\_ Vision;  
\_\_\_ Prescription Drug; \_\_\_ Mental Health;  
\_\_\_ Other (specify): \_\_\_\_\_  
Premium Cost/Frequency  
to enroll child(ren): \$ \_\_\_\_\_ per \_\_\_\_\_

Insurance Company: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_  
\*Policy #: \_\_\_\_\_ \*Group #: \_\_\_\_\_  
Coverage Available (Check all that apply):  
\_\_\_ Medical; \_\_\_ Dental; \_\_\_ Vision;  
\_\_\_ Prescription Drug; \_\_\_ Mental Health;  
\_\_\_ Other (specify): \_\_\_\_\_  
Premium Cost/Frequency  
to enroll child(ren): \$ \_\_\_\_\_ per \_\_\_\_\_

(\* Policy # or Group # is required)

INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on Part B.

- (A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a "qualified medical child support order" (QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 business days of the date of this Notice, or sooner if reasonable:
- (1) Complete Part B - Plan Administrator Response - and send it to the Issuing Agency:
    - (a) if you checked Response 2:
      - (i) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);
      - (ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;
    - (b) if you checked Response 3:
      - (i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional participant contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;
      - (ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency.
    - (c) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and
    - (d) upon completion of the enrollment, transfer the applicable information on Part B - Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete Response 5 of Part B - Plan Administrator Response and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination.

- (C) Any required notification of the custodial parent, child(ren) and/or participant may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate. You may choose to furnish these notifications electronically in accordance with the requirements of the Department of Labor's electronic disclosure regulation codified at 29 C.F.R. 2520.104b-1(c).

UNLAWFUL REFUSAL TO ENROLL

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the participant's Federal income tax return; (3) the child does not reside with the participant or in the plan's service area; or (4) because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, you must enroll both the participant and the child(ren) regardless of whether the participant has applied for enrollment in the plan. All enrollments are to be made without regard to open season restrictions.

PAYMENT OF CLAIMS

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

PERIOD OF COVERAGE

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

- (1) The plan administrator is provided satisfactory written evidence that either:
  - (a) the court or administrative child support order referred to above is no longer in effect, or
  - (b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;
- (2) The employer eliminates family health coverage for all of its employees; or
- (3) Any available continuation coverage is not elected, or the period of such coverage expires.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

PAPERWORK REDUCTION ACT NOTICE

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act or the Child Support Performance and Incentive Act, as applicable. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

	Learning about the law or the form -----	Preparing the form -----
First Notice	1 hr.	1 hr., 45 min.
Subsequent Notices	-----	20 min



Employer's Name: LAKE REGIONAL MEDICAL  
EMPLOYEE/OBLIGOR'S Name: JENKS, BRIAN PEYTON  
CSE Agency Case ID: 0004743210

Employer FEIN: 541480585  
SSN: 242517707  
Order ID: \_\_\_\_\_

For electronic payment and processing (EFT) information log on to the Virginia Department of Social Services, My Child Support Payments website at: <https://mychildsupport.dss.virginia.gov>; or for electronic payment requirements, you may call 1-800-468-8894 before the first submission of a payment. For centralized payment collection and disbursement facility information (State Disbursement Unit (SDU)), see [www.acf.hhs.gov/programs/css/employers/electronic-payments](http://www.acf.hhs.gov/programs/css/employers/electronic-payments). Virginia Code #20-79.3 requires employers with at least 100 employees and all payroll processing firms with at least 50 clients to remit payments by electronic funds transfer. Payment shall be transmitted within four days of the obligor's regular pay date.

Include the Remittance ID with the EFT payment and if necessary this FIPS code: 51000

Make payment payable to Treasurer of Virginia  
and remit payment to Division of Child Support Enforcement (SDU)  
at P.O. Box 570, Richmond, VA 23218-0570

If paying by check, include the employee/obligor's name along with their Social Security Number and/or DCSE Case Number.

( ) Return to Sender (Completed by Employer/Income Withholder). Payment must be directed to an SDU in accordance with 42 USC #666(b)(5) and (b)(6) or Tribal Payee (see Payments to SDU below). If payment is not directed to an SDU/Tribal Payee or this IWO is not regular on its face, you must check this box and return the IWO to the sender.

Signature of Judge/Issuing Official: Marshall S. Warren  
(if required by state or tribal law)  
Print Name of Judge/Issuing Official: MARSHALL WARREN  
Title of Judge/Issuing Official: Support Enforcement Specialist  
Date of Signature: \_\_\_\_\_

If the employee/obligor works in a state or for a tribe that is different from the state or tribe that issued this order, a copy of this IWO must be provided to the employee/obligor.

(X) If checked, the employer/income withholder must provide a copy of this form to the employee/obligor.

#### ADDITIONAL INFORMATION FOR EMPLOYERS/INCOME WITHHOLDERS

State-specific contact and withholding information can be found on the Federal Employer Services website located at:  
[www.acf.hhs.gov/programs/css/resource/state-income-withholding-contacts-and-program-information](http://www.acf.hhs.gov/programs/css/resource/state-income-withholding-contacts-and-program-information)

Priority: Withholding for support has priority over any other legal process under State law against the same income (42 USC #666(b)(7)). If a federal tax levy is in effect, please notify the sender.

Combining Payments: When remitting payments to an SDU or tribal CSE agency, you may combine withheld amounts from more than one employee/obligor's income in a single payment. You must, however, separately identify each employee/obligor's portion of the payment.

Payments to SDU: You must send child support payments payable by income withholding to the appropriate SDU or to a tribal CSE agency. If this IWO instructs you to send a payment to an entity other than an SDU (e.g., payable to the custodial party, court, or attorney), you must check the box above and return this notice to the sender. Exception: If this IWO was sent by a court, attorney, or private individual/entity and the initial order was entered before January 1, 1994 or the order was issued by a tribal CSE agency, you must follow the "Remit payment to" instructions on this form.

Reporting the Pay Date: You must report the pay date when sending the payment. The pay date is the date on which the amount was withheld from the employee/obligor's wages. You must comply with the law of the state (or tribal law if applicable) of the employee/obligor's principal place of employment regarding time periods within which you must implement the withholding and forward the support payments.

OMB Expiration Date - 07/31/2017. The OMB Expiration Date has no bearing on the termination date of the IWO; it identifies the version of the form currently in use.

**Multiple IWOs:** If there is more than one IWO against this employee/obligor and you are unable to fully honor all IWOs due to federal, state or tribal withholding limits, you must honor all IWOs to the greatest extent possible, giving priority to current support before payment of any past-due support. Follow the state or tribal law/procedure of the employee/obligor's principal place of employment to determine the appropriate allocation method.

**Lump Sum Payments:** You may be required to notify a state or tribal CSE agency of upcoming lump sum payments to this employee/obligor such as bonuses, commissions, or severance pay. Contact the sender to determine if you are required to report and/or withhold lump sum payments.

**Liability:** If you have any doubts about the validity of this IWO, contact the sender. If you fail to withhold income from the employee/obligor's income as the IWO directs, you are liable for both the accumulated amount you should have withheld and any penalties set by state or tribal law/procedure. In Virginia those penalties can be found in Virginia Code #20-79.3 and 16.1-278.16.

**Anti-discrimination:** You are subject to a fine determined under state or tribal law for discharging an employee/obligor from employment, refusing to employ, or taking disciplinary action against an employee/obligor because of this IWO. The employee/obligor's rights are protected pursuant to Virginia Code #20-79.3(A) (9) and 63.2-1944.

**Withholding Limits:** You may not withhold more than the lesser of: 1) the amounts allowed by the Federal Consumer Credit Protection Act (CCPA) (15 U.S.C. #1673(b)); or 2) the amounts allowed by the state of the employee/obligor's principal place of employment or tribal law if a tribal order (see Remittance Information). Disposable income is the net income after mandatory deductions such as: state, federal, local taxes; Social Security taxes; statutory pension contributions; and Medicare taxes. The federal limit is 50% of the disposable income if the obligor is supporting another family and 60% of the disposable income if the obligor is not supporting another family. However, those limits increase 5% - to 55% and 65% - if the arrears are greater than 12 weeks. If permitted by the state or tribe, you may deduct a fee for administrative costs. The combined support amount and fee may not exceed the limit indicated in this section.

For tribal orders, you may not withhold more than the amounts allowed under the law of the issuing tribe. For tribal employers/income withholders who receive a state IWO, you may not withhold more than the limit set by tribal law.

Depending upon applicable state or tribal law, you may need to consider amounts paid for health care premiums in determining disposable income and applying appropriate withholding limits.

Arrears greater than 12 weeks? If the Order Information does not indicate that the arrears are greater than 12 weeks, then the employer should calculate the CCPA limit using the lower percentage.

**Supplemental Information:** Virginia employers may (but do not have to) deduct a \$5.00 fee to cover administrative costs for each deduction for support or each reply stating that no funds are available. This amount is in addition to the amount of the income withholding. If you have questions regarding this order, you may call the Employer Inquiry helpline at 1-800-257-9986 or you may contact the district office listed on the last page of this document. Virginia Code #63.2-1924 and 63.2-1942 permit the employee/obligor to contest this order. If the employee/obligor does so, a written request for an appeal must be sent to: Hearing Officer, 801 E. Main Street, Richmond, VA 23219-2901 within 10 days from the date of receipt of this notice. If you cannot withhold enough to cover both the support payment and the insurance premium because their total exceeds the maximum percentage allowed under the Consumer Credit Protection Act, your priority should be:

( ) insurance premium      (X) support payment based on Virginia Code # 20-79.3 and 34-29.

If the obligor is a non-employee, you may not withhold more than 50% of the earnings if the obligor is supporting another family and 60% of the earnings if the obligor is not supporting another family. However, those limits increase 5% - to 55% and 65% - if the arrears are greater than 12 weeks. The appropriate amount will be the same that is reflected under Remittance Information for the % of disposable earnings.

**IMPORTANT:** The person completing this form is advised that the information may be shared with the employee/obligor.

Employer's Name: LAKE REGIONAL MEDICAL  
Employee/Obligor's Name: JENKS, BRIAN PEYTON  
CSE AGENCY Case ID: 0004743210

Employer FEIN: 541480585  
SSN: 242517707  
Order ID: \_\_\_\_\_

NOTIFICATION OF EMPLOYMENT TERMINATION OR INCOME STATUS: If this employee/obligor never worked for you or you are no longer withholding income for this employee/obligor, you must promptly notify the CSE agency and/or the sender by returning this form to the address listed in the contact information below:

- ( ) This person has never worked for this employer nor received periodic income.
- ( ) This person no longer works for this employer nor receives periodic income.

Please provide the following information for the employee/obligor:

Termination date: \_\_\_\_\_ Last known phone number: \_\_\_\_\_

Last known address: \_\_\_\_\_

Final payment date to SDU/tribal payee: \_\_\_\_\_

Final payment amount: \_\_\_\_\_

New employer's name: \_\_\_\_\_

New employer's address: \_\_\_\_\_

CONTACT INFORMATION:

To Employer/Income Withholder: If you have any questions, contact:  
MARSHALL WARREN by phone 800-468-8894  
by FAX 540-857-7841  
by e-mail or website:

Send termination/income status notice and other correspondence to:

ROANOKE DISTRICT OFFICE  
CHILD SUPPORT ENFORCEMENT  
3535 FRANKLIN ROAD SW SUITE H  
ROANOKE VA 24014 2255

To Employee/Obligor: If the employee/obligor has questions, contact:  
MARSHALL WARREN by phone 800-468-8894  
by FAX 540-857-7841  
by e-mail or website:

The Paperwork Reduction Act of 1995

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This information collection and associated responses are conducted in accordance with 45 CFR 303.100 of the Child Support Enforcement Program. This form is designed to provide uniformity and standardization. Public reporting burden for this collection of information is estimated to average 5 minutes per response for Non-IV-D CPs; 2 minutes per response for employers; 3 seconds for e-IWO employers, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

