



**Massachusetts Department of Revenue  
Child Support Enforcement Division**

Michael J. Heffernan, Commissioner  
Michele A. Cristello, Deputy Commissioner



CORPORATE MANAGEMENT GROUP, INC.  
ATTN: PAYROLL  
13495 CLAYTON CT.  
THORNTON, CO 80241-0000

08/10/2016

Dear Employer,

The Massachusetts Department of Revenue (DOR) has been notified that one of your employees must provide health care coverage for his or her children because of a court order. The employee's name is on the attached National Medical Support Notice.

You must enroll the children on the notice in your employee's health care plan. Please read the notice and respond by the due date. If you or your health insurance company doesn't follow the notice and doesn't have a good reason (reasonable cause), a court may hold you responsible for all of the child's medical costs.

You can find instructions for your health plan administrator in the brochure that's included with the notice.

Learn more about the National Medical Support Notice on our website under Programs & Services for Employers:

[WWW.MASS.GOV/CSE](http://WWW.MASS.GOV/CSE)

You may **not** give your employee any personal information from the National Medical Support Notice, such as the other parent's address or the child's Social Security number. You may **not** share that information with anyone who isn't authorized to have it.

If you have any questions, please call us at (866)330-6752. Thank you.

Sincerely,

Massachusetts Department of Revenue  
Child Support Enforcement Division





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:<br>MASSACHUSETTS DEPARTMENT OF REVENUE<br>CHILD SUPPORT ENFORCEMENT DIVISION<br>Issuing Agency Address:<br>P.O. BOX 55261<br>BOSTON, MA 02205-5261<br><br>Notice Date: 08/10/2016<br>CSE Agency Case Identifier: 006.182.168<br>Telephone Number: (866)330-6752<br>FAX Number: (617)471-8062 | Court or Administrative Authority: HAMPDEN PROBATE & FAMILY COURT<br>Order Date: 04/03/2008<br>Order Identifier: P6300618216801<br>Document Tracking Identifier:<br>Employer Website: WWW.MASS.GOV/CSE<br>See NMSN Instructions:<br><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> |
|--|---|

201535646  
Employer/Withholder's Federal EIN Number  
CORPORATE MANAGEMENT GROUP, INC.  
Employer/Withholder's Name  
ATTN: PAYROLL  
13495 CLAYTON CT.  
THORNTON, CO 80241-0000  
Employer/Withholder's Address

SLACHTA JENNIFER ANN  
Custodial Parent's Name (Last, First, MI)  
73 VAIL ST  
SPRINGFIELD, MA 01118-2162

Custodial Parent's Mailing Address

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

Name and Telephone Number of a Representative of the Child(ren)

|                          |        |
|--------------------------|--------|
| Child(ren)'s Name(s)     | Gender |
| SLACHTA MADISON DOROTHEA | F      |

RE:  
SLACHTA J. GREGORY ANDREW  
Employee's Name (Last, First, MI)

023-68-3940  
Employee's Social Security Number

30 RIVER ST APT 2  
FRANKLIN, NH 03235-0000

Employee's Mailing Address

Substituted Official/Agency Name

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

Mailing Address of a Representative of the Child(ren)

|            |             |
|------------|-------------|
| DOB        | SSN         |
| 05/02/2003 | 026-86-5448 |

The order requires the child (ren) to be enrolled in  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.





### **LIMITATIONS ON WITHHOLDING**

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

- 1) The amounts allowed by the Consumer Credit Protection Act (CCPA) (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 amount allowed for health insurance premiums by the child support order.

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, in the instructions to employer, 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 the purpose 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 below:

- 1) Deduct the amount required to pay the current monthly child, family and/or spousal support (not including any periodic payment toward arrears),
- 2) Deduct the amount required to pay the current monthly family health premiums and/or other current medical support,
- 3) Deduct any amount ordered for the payment of arrears,
- 4) Deduct any remaining ordered amounts.

As required under section 2.b.2 of the Employer Responsibilities in the instructions to employer, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.





**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/YYYY

**CONTACT FOR QUESTIONS**

Plan Administrator Name:

Contact Person:

FAX Number:

Telephone Number:

Employer Name:

Employer Representative Name:

Employer Representative Title:

Telephone Number:

Federal EIN:  (if not provided by Issuing Agency on Page 1 of this Notice)

Employee Name:

Date:

Case #:006.182.168



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 Act 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.

Table with 2 columns: Issuing Agency details (Massachusetts Department of Revenue) and Court or Administrative Authority details (Hampden Probate & Family Court).

201535646
Employer/Withholder's Federal EIN Number
CORPORATE MANAGEMENT GROUP, INC.
Employer/Withholder's Name
ATTN: PAYROLL
13495 CLAYTON CT.
THORNTON, CO 80241-0000
Employer/Withholder's Address

RE: SLACHTA J. GREGORY ANDREW
Employee's Name (Last, First, MI)

023-68-3940
Employee's Social Security Number

30 RIVER ST APT 2
FRANKLIN, NH 03235-0000

Employee's Mailing Address

SLACHTA JENNIFER ANN
Custodial Parent's Name (Last, First, MI)
73 VAIL ST
SPRINGFIELD, MA 01118-2162

Substituted Official/Agency Name

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)

Child(ren)'s Name(s) Gender DOB SSN
SLACHTA MADISON DOROTHEA F 05/02/2003 026-86-5448

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 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.



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**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 #: 006.182.168

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 recipient(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):

[ ]

Provider

[ ]

Policy Number

[ ]

Group Number

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 a 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:

Title:

Date:  Telephone Number:

Address:

