CS-72
(R. 4/15)
921 KAR 1:410

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Income Support
Child Support Enforcement

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 purpose of this form, the Custodial Parent may also be the employee when a State opts to enforce against the Custodial Parent.

Issuing Agency: Kentucky Child Support Enforcement COURT Issuing Agency Address: 20 N MAIN ST STE 201 HENDERSON, KY 42420 Date of Notice: 06/22/2017 CSE Agency Case Identifier: 340-78-6283 Telephone Number: (270)827-5753 FAX Number: 270-827-6032	Court or Administrative Authority: HENDERSON CIRCUIT Order Date: 01/01/2014 Order Identifier: 13-J-349 Document Tracking Identifier: Employer web site: See NMSN Instructions http://acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

201535646
Employer/Withholder's Federal EIN Number

RE: MCCORMICK, NATHAN
Employee's Name (Last, First, MI)

CORPORATE MGMT GROUP INC
Employer/Withholder's Name

340-78-6283
Employee's Social Security Number

12000 WASHINGTON ST STE 290 THORNTON, CO 80241 3133
Employer/Withholder's Address

328 E 2ND ST APT 1
MOUNT VERNON, IN 47620
Employee's Mailing Address

METKER, HEATHERLE, A.
Custodial Parent's Name (Last, First, MI)

Kentucky Child Support Enforcement
Substituted Official/Agency Name

7410 HIGHWAY 136 W

CALHOUN, KY 42327 9579
Custodial Parent's Mailing Address

REBECCA WILSON
20 N MAIN ST STE 201
HENDERSON, KY 42420
Substituted Official/Agency Name
(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 Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN
KHOVEL J. MCCORMICK	MALE	05/13/2011	345-11-1041				
KAYCEN R. MCCORMICK	MALE	01/08/2013	052-95-3019				

The order requires the child(ren) to be enrolled in [X] any health coverages available; or [ ] only the following coverage(s):
__Medical; __Dental; __Vision; __Prescription Drug; __Mental Health; __Other (specify):_____

LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed 5 % 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: Pursuant to KRS 403.211(8)(a) the cost of coverage cannot exceed 5% of the responsible parent's gross income. The 5% standard applies to the cost of adding a child to an existing policy, the difference in the cost between a single and a family plan, or the cost of acquiring a separate policy to cover the child.

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: Pursuant to KRS 405.467(8) priority is given to the current child support obligation.
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.

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 the Notice has never been employed by this employer.

☐ 2. We, the employer, do not offer 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 the 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: _____

OMB control number 1210-0113

INSTRUCTIONS TO EMPLOYER

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 already has 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 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 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) without 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 the 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 on page 1 of this Notice.

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department of Income Support
Child Support Enforcement

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. 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 the 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: Kentucky Child Support Enforcement COURT Issuing Agency Address: 20 N MAIN ST STE 201 HENDERSON, KY 42420 Date of Notice: 06/22/2017 CSE Agency Case identifier: 340-78-6283 Telephone Number: (270)827-5753 FAX Number: 270-827-6032	Court or Administrative Authority: HENDERSON CIRCUIT Order Date: 01/01/2014 Order Identifier: 13-J-349 Document Tracking Identifier: Employer web site: See NMSN Instructions http://acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

201535646
Employer/Withholder's Federal EIN Number

RE: MCCORMICK, NATHAN
Employee's Name (Last, First, MI)

CORPORATE MGMT GROUP INC
Employer/Withholder's Name

340-78-6283
Employee's Social Security Number

12000 WASHINGTON ST STE 290 THORNTON, CO 80241 3133
Employer/Withholder's Address

328 E 2ND ST APT 1
MOUNT VERNON, IN 47620
Employee's Mailing Address

METKER, HEATHERLE, A.
Custodial Parent's Name (Last, First, MI)

Kentucky Child Support Enforcement
Substituted Official /Agency Name

7410 HIGHWAY 136 W

CALHOUN, KY 42327 9579
Custodial Parent's Mailing Address

REBECCA WILSON
20 N MAIN ST STE 201
HENDERSON, KY 42420
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	Child(ren)'s Name(s)	Gender	DOB	SSN
KHOVEL J. MCCORMICK	MALE	05/13/2011	345-11-1041				
KAYCEN R. MCCORMICK	MALE	01/08/2013	052-95-3019				

The order requires the child(ren) to be enrolled in [X] any health coverages available; or [ ] only the following coverage(s):
__Medical; __Dental; __Vision; __Prescription Drug; __Mental Health; __Other (specify):_____

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)

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: _____. 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: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____

OMB control number 1210-0113

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 is 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

OMB control number 1210-0113

(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.

(B) 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 that is required may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate.

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). 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 on page six.

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.

OMB control number 1210-0113

CS-89
(R. 2/16)
921 KAR 1:410

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Income Support
Child Support Enforcement

INCOME WITHHOLDING FOR SUPPORT

[X] ORIGINAL INCOME WITHHOLDING ORDER/NOTICE FOR SUPPORT (IWO)
[] AMENDED IWO
[] ONE-TIME ORDER/NOTICE FOR LUMP SUM PAYMENT
[] TERMINATION OF IWO

Date 6/22/2017

[X] Child Support Enforcement (CSE) Agency ☐ Court ☐ Attorney ☐ Private Individual/Entity (Check One)

NOTE: This IWO must be regular on its face. Under certain circumstances you must reject this IWO and return it to the sender (see IWO instructions www.acf.hhs.gov/programs/css/resource/income-withholding-for-support-instructions). If you receive this document from someone other than a state or tribal CSE agency or a court, a copy of the underlying order must be attached.

State/Tribe/Territory KENTUCKY
City/County/Dist./Tribe HENDERSON
Private Individual/Entity

Remittance ID (include w/payment) 340-78-6283
Order ID 13-J-349
CSE Agency Case ID 0005321880

CORPORATE MGMT GROUP INC
Employer/Income Withholder's Name
12000 WASHINGTON ST STE 290

THORNTON, CO 80241 3133

Employer/Income Withholder's Address

Employer/Income Withholder's FEIN 201535646

RE: MCCORMICK, NATHAN
Employee/Obligor's Name (Last, First, Middle)
340-78-6283
Employee/Obligor's Social Security Number
METKER, HEATHERLE, A.
Custodial Party/Obligee's Name (Last, First, Middle)

Child(ren)'s Name(s) (Last, First, Middle)	Child(ren)'s Birth Date(s)
MCCORMICK, KHOVEL, J.	05/13/2011
MCCORMICK, KAYCEN, R.	01/08/2013

ORDER INFORMATION: This document is based on the support or withholding order from KENTUCKY (State/Tribe). You are required by law to deduct these amounts from the employee/obligor's income until further notice.

$693.00	Per Month	current child support
XXX	Per Month	past-due child support - **Arrears greater than 12 weeks?** () Yes (X) No
XXX	Per Month	current cash medical support
XXX	Per Month	past-due cash medical support
XXX	Per Month	current spousal support
XXX	Per Month	past-due spousal support
XXX	Per Month	other (must specify)

for a **Total Amount to Withhold** of $693.00 per month.

AMOUNTS TO WITHHOLD: You do not have to vary your pay cycle to be in compliance with the *Order Information*. If your pay cycle does not match the ordered payment cycle, withhold one of the following amounts:

$159.92 per weekly pay period
$319.85 per biweekly pay period (every two weeks)
$346.50 per semimonthly pay period (twice a month)
$693.00 per monthly pay period

$ **LUMP SUM PAYMENT:** Do not stop any existing IWO unless you receive a termination order.

Document Tracking ID _____

OMB 0970-0154

Employer's Name: CORPORATE MGMT GROUP INC Employer FEIN: 201535646

Employee/Obligor's Name: MCCORMICK, NATHAN SSN: 340-78-6283

CSE Agency Case Identifier: 0005321880 Order Identifier: 13-J-349

REMITTANCE INFORMATION: If the employee/obligor's principal place of employment is Kentucky (State/Tribe), you must begin withholding no later than the first pay period that occurs 14 days after the date of 06/22/2017. Send payment within 7 working days of the pay date. If you cannot withhold the full amount of support for any or all orders for this employee/obligor, withhold up to **50** % of disposable income. If the obligor is a non-employee, obtain withholding limits from Supplemental Information on page 3. If the employee/obligor's principal place of employment is not Kentucky (State/Tribe), obtain withholding limitations, time requirements, and any allowable employer fees at www.acf.hhs.gov/programs/css/resource/state-income-withholding-contacts-and-program-information for the employee/obligor's principal place of employment.

For electronic payment requirements and centralized payment collection and disbursement facility information (State Disbursement Unit [SDU]), see www.acf.hhs.gov/programs/css/employers/electronic-payments.

Include the ***Remittance ID*** **with the payment** and if necessary this FIPS code 21000.

Remit Payment to Kentucky Child Support Enforcement (SDU/Tribal Order Payee) at PO Box 14059, Lexington, KY 40512-4059.

☐ **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 (if Required by State or Tribal Law): Rebecca Wilson
Print Name of Judge/Issuing Official: REBECCA WILSON
Title of Judge/Issuing Official: CSE Investigator
Date of Signature: 6/22/17

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.

☐ 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 Service website located at:
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.

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.

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.

Employer's Name: CORPORATE MGMT GROUP INC Employer FEIN: 201535646

Employee/Obligor's Name: MCCORMICK, NATHAN SSN: 340-78-6283

CSE Agency Case Identifier: 0005321880 Order Identifier: 13-J-349

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.

For Kentucky employers, KRS 405.467(10) states that you are liable to CHFS for any amount that you fail to withhold following receipt of this Order/Notice.

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.

For Kentucky employers, KRS 405.991 requires that any person or corporation violating KRS 405.465 or 405.467 shall be fined not more than $500 or be imprisoned not more than one year or both.

Withholding Limits: You may not withhold more than the lesser of: 1) the amounts allowed by the Federal Consumer Credit Protection Act (CCPA) (15 USC §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 the 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 the 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:

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

Employer's Name: CORPORATE MGMT GROUP INC Employer FEIN: 201535646

Employee/Obligor's Name: MCCORMICK, NATHAN SSN: 340-78-6283

CSE Agency Case Identifier: 0005321880 Order Identifier: 13-J-349

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 REBECCA WILSON (Issuer Name) by phone: (270) 827-5753, by fax: **270-827-6032**, by e-mail or website: **270-827-6032**

Send termination/income status notice and other correspondence to: 20 N MAIN ST STE 201 HENDERSON, KY 42420

To Employee/Obligor: If the employee/obligor has questions, contact REBECCA WILSON by phone: (270) 827-5753, by fax: **270-827-6032**, by e-mail or website: **270-827-6032**

The Paperwork Reduction Act of 1995

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 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.