

IL Dept of Healthcare and Family Services  
Division of Child Support Services  
CUSTOMER SERVICE  
PO BOX 641097 AIDMAXKF  
CHICAGO IL 60664-1097

RECEIVED  
2/16/16

ATTN: PAYROLL DEPT.  
LAKE REGION MEDICAL  
140 E HINTZ RD  
WHEELING IL 60090-6044

INSTRUCTIONS FOR RESPONDING TO THIS ORDER ARE ON THE BACK OF THIS PAGE

**HOT NEWS!**

PLEASE REMEMBER TO SEND ALL CHILD SUPPORT PAYMENTS ONLY TO SDU:  
P.O. BOX 5400 CARDL STREAM, ILLINDIS 60197-5400

YOU MUST REPORT ALL NEW HIRES TO IL DEPT OF EMPLOYMENT SEC. WITHIN 20 DAYS OF START DATE.  
QUESTIONS CALL: 1-888-245-1938.

IF YOUR INCOME WITHHOLDING/GARNISHMENT ADDRESS IS DIFFERENT FROM THE ADDRESS LISTED ABOVE,  
PLEASE PROVIDE BELOW AND FAX TO 217-524-1218.

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PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

IL Dept of Healthcare and Family Services  
Division of Child Support Services  
CUSTOMER SERVICE  
PO BOX 641097 AIDMAXKF  
CHICAGO IL 60664-1097

FOR OFFICE USE ONLY (IMAGING)

CASE NUMBER: CO1739697

NCP RIN: 063953152

CP RIN: 060500840

LAKE REGION MEDICAL  
140 E HINTZ RD  
WHEELING IL 60090-6044



RE: TERRY BEALS  
409-49-5013  
FIPS/DOCKET#: 1700000/237P20050183

**THE INFORMATION CONTAINED IN THIS PACKET IS CONFIDENTIAL  
DO NOT MAIL CHILD SUPPORT CHECKS IN THE ENVELOPE PROVIDED**

**IF THE EMPLOYEE LISTED ABOVE IS NOT PRESENTLY EMPLOYED BY YOUR COMPANY, PLEASE COMPLETE THIS PAGE,  
FAX IT TO THE NUMBER BELOW AND DISCARD ALL OTHER FORMS IN THIS PACKET. IF YOU ARE UNABLE TO FAX  
THIS PAGE, PLEASE MAIL IT IN THE ENVELOPE PROVIDED. IF PERSON IS AN EMPLOYEE, PLEASE READ ALL  
DOCUMENTS IN THE PACKET AND RESPOND AS DIRECTED.**

FAX RESPONSES TO: (888) 227-0370  
IF YOU HAVE QUESTIONS, CALL: 1-888-245-1938

**MARK THE BOX THAT APPLIES:**

1.  **NEVER EMPLOYED:** THE PERSON NAMED ABOVE WAS NEVER ADDED TO YOUR PAYROLL.

2.  **NO LONGER EMPLOYED:** THE PERSON NAMED ABOVE IS NO LONGER YOUR EMPLOYEE.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

DATE TERMINATED \_\_\_\_\_

LAST KNOWN ADDRESS \_\_\_\_\_

LAST KNOWN TELEPHONE NUMBER: \_\_\_\_\_

NEW EMPLOYER (IF KNOWN): \_\_\_\_\_

NEW EMPLOYER ADDRESS: \_\_\_\_\_

NEW EMPLOYER TELEPHONE NUMBER: \_\_\_\_\_

NAME OF PERSON COMPLETING THIS FORM: \_\_\_\_\_

PHONE#: \_\_\_\_\_

DATE: \_\_\_\_\_

**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: <u>IL Healthcare and Family Services</u>	Court or Administrative Authority: <u>1700000</u>
Issuing Agency Address: <u>PD Box 641097, Chicago IL 60664-1097</u>	Order Date: <u>10/31/2005</u>
Notice Date: <u>OCTOBER 30, 2015</u>	Order Identifier: <u>237P20050183</u>
CSE Agency Case Identifier: <u>CO1739697</u>	Document Tracking Identifier: _____
Telephone Number: <u>1-888-245-1938</u>	Employer web site: <u>www.ilchildsupport-employer.com</u>
FAX Number: <u>(888) 227-0370</u>	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>

Employer/Withholder's FEIN Number	RE: <u>BEALS, TERRY</u> <u>063953152</u>
<u>LAKE REGION MEDICAL</u>	Employee's Name (Last, First, MI)
Employer/Withholder's Name	<u>409-49-5013</u>
<u>140 E HINTZ RD</u>	Employee's Social Security Number
<u>WHEELING IL 60090-6044</u>	<u>2030 N SAYRE AVE</u>
Employer/Withholder's Address	Employee's Mailing Address
<u>LOCKETT, TIANTE</u> <u>060500840</u>	<u>CHICAGO IL 60707-3822</u>
Custodial Parent's Name (Last, First, MI)	Substituted Official/Agency Name
<u>3301 WIRETON RD</u>	
<u>BLUE ISLAND IL 60406-2442</u>	
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
<u>AMARIJAH BEALS</u>	<u>FEMALE</u>	<u>01/08/2003</u>	<u>339-02-8423</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The order requires the child(ren) to be enrolled in:  
 all health coverages available; or  
 only the following coverage(s): X 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 prior page, 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: Income available for withholding shall be applied first to the current support obligation, then to any premium required for employer, labor union, or trade union-related health insurance coverage ordered under the order for support, and then to payment required on past due support obligations. If there is insufficient available income remaining to pay the full amount of the required health insurance premium after withholding of income for the current support obligation, then the remaining available income shall be applied to payment required on past-due support obligations. If the payor has been served with more than one income withholding notice pertaining to the same obligor, the payor shall allocate income available for withholding on a proportionate share basis, giving priority to current support payments. (750 ILCS 28/35(c)) As required under section 2.b.2 of the Employer Responsibilities on prior page, 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 either 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: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

FAX Number: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_  
Employer Representative Name/Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_  
Federal EIN: \_\_\_\_\_  
(if not provided on Page 1 of this Notice)  
Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_



**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.

Issuing Agency: <u>IL Healthcare and Family Services</u>	Court or Administrative Authority: <u>1700000</u>
Issuing Agency Address: <u>PO Box 641097, Chicago IL 60664-1097</u>	Order Date: <u>10/31/2005</u>
Notice Date: <u>OCTOBER 30, 2015</u>	Order Identifier: <u>237P20050183</u>
CSE Agency Case Identifier: <u>CO1739697</u>	Document Tracking Identifier: _____
Telephone Number: <u>1-888-245-1938</u>	Employer web site: <u>www.ilchildsupport-employer.com</u>
FAX Number: <u>(888) 227-0370</u>	See NMSN Instructions: <u>http://www.acf.hhs.gov/programs.css/resource/national-medical-support-notice-form</u>

Employer/Withholder's Federal EIN Number	RE: <u>BEALS, TERRY</u> <u>063953152</u>
<u>LAKE REGION MEDICAL</u>	Employee's Name (Last, First, MI)
Employer/Withholder's Name	<u>409-49-5013</u>
<u>140 E HINTZ RD</u>	Employee's Social Security Number
<u>WHEELING IL 60090-6044</u>	<u>2030 N SAYRE AVE</u>
Employer/Withholder's Address	<u>CHICAGO IL 60707-3822</u>
<u>LOCKETT, TIANTE</u> <u>060500840</u>	Employee's Mailing Address
Custodial Parent's Name (Last, First, MI)	Substituted Official/Agency Name
<u>3301 WIRETON RD</u>	
<u>BLUE ISLAND IL 60406-2442</u>	
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)	DOB
<u>AMARIJAH BEALS</u>	<u>01/08/2003</u>
Gender	SSN
<u>FEMALE</u>	<u>339-02-8423</u>
_____	_____
_____	_____
_____	_____

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

any health coverages available; or

only the following coverage(s): X 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.  
**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 #: CO1739697

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): \_\_\_\_\_. 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 \_\_\_\_\_

Plan Administrator or Representative:

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

IL Dept of Healthcare and Family Services  
Division of Child Support Services  
Medical Support Unit  
PO Box 641097  
Chicago IL 60664-1097

ATTN: PAYROLL DEPT.  
LAKE REGION MEDICAL  
140 E HINTZ RD  
WHEELING IL 60090-6044

Obligor: TERRY BEALS Date: OCTOBER 30, 2015  
RIN: 063953152  
FIPS/Docket: 1700000/237P20050183 SSN: XXX-XX-5013  
Case Number: CO1739697  
Obligee: TIANTE LOCKETT RIN: 060500840

COMPLETE REVERSE SIDE AND RETURN

#### HIPAA PRIVACY

Please be advised that your Plan Administrator must comply with the requirements of the National Medical Support Notice (NMSN) served on you by Healthcare and Family Services (HFS). Your Plan Administrator may claim that the federal Health Insurance Portability and Accountability Act (HIPAA) (Pub. L.104-191) prohibits the Plan Administrator from disclosing the requested information.

Our Department's Office of General Counsel has stated that HIPAA's privacy rule (45 CFR Part 160 and Part 164 subpart A and E) does NOT prohibit the Plan Administrator from complying with the requirements of the NMSN (HFS 3554) or any other insurance coverage report the Department may provide, including the Health Insurance Report (HFS 1442A), or enrolling the Obligor's minor children named in the NMSN in your health plan.

The privacy rule permits a covered entity "to use or disclose protected health information to the extent that such use or disclosure is required by law". 45 CFR Section 164.512(a).

Compliance with the requirements of the NMSN, providing requested information to the State child support enforcement agency regarding enrollment of child support obligors' children, is required by State and federal law and regulation, including 42 USC Section 666(a)(19); 29 USC Section 1169(a); 45 CFR Sections 303.30(a)(7), 303.32, 160.103; 29 CFR Section 2590; 750 ILCS Section 5/505.2; and 750 ILCS Section 28/22.

Specifically, Section 505.2 of the Illinois Marriage and Dissolution of Marriage Act states:

- (f) Disclosure of information. The obligor's employer or labor union or trade union shall disclose to the obligee or Public Office, upon request, information concerning any dependent coverage plans which would be made available to a new employee or labor union member or trade union member. The employer or labor union or trade union shall disclose such information whether or not a court order for medical support has been entered.

750 ILCS 5/505.2(f); and Section 22 of the Income Withholding for Support Act state:

- (f) The administrator of a health insurance plan to whom an employer has transferred the severable notice to plan administrator part of a National Medical Support Notice shall complete that part with the health insurance coverage information required under the instructions in the Notice and shall return that part to the Title IV-D Agency within 40 business days after the date of the Notice.

Your failure or the failure of your Plan Administrator to comply with the requirements of the NMSN may result in the Department filing a complaint against you in court. 750 ILCS 28/50(a).

If you have any questions, you may contact HFS' Income Withholding and Medical Support Unit at 1-888-245-1938.

103015                      CO1739697                      060500840                      063953152                      237P20050183

HFS 3570 (R-6-12)

HEALTH INSURANCE REPORT

4(PERMANENT)

1. NCP NAME TERRY BEALS RIN 063953152 IV-A # 94-226-000160081  
 CP NAME TIANTE LOCKETT RIN 060500840 IV-D # CO1739697  
 FIPS/DOCKET # 1700000/237P20050183

2. Must be Completed

POLICYHOLDER/EMPLOYEE - LAST FIRST MI  
 DATE OF BIRTH SOCIAL SECURITY NUMBER INSURANCE BEGIN DATE INSURANCE END DATE

3. Complete for Individual Health/Hospital Insurance Only

INSURANCE COMPANY CERTIFICATE/POLICY #  
 STREET CITY ST ZIP

4. Complete Only if Insurance IS Through Employer/Union

LAKE REGION MEDICAL EMPLOYER/UNION EMPLOYER FEIN UNION LOCAL #  
 140 E HINTZ RD WHEELING IL 600906044  
 STREET CITY ST ZIP

INSURANCE COMPANY GROUP # CERTIFICATE/POLICY #

5. Where Are Claims Mailed?

MEDICAL CLAIMS TO - NAME STREET CITY ST ZIP

RX DRUG CLAIMS TO - NAME STREET CITY ST ZIP

6. Check if the Following Benefits are Provided:

MAJ MED: \_\_\_\_\_ DENTAL: \_\_\_\_\_ VISION: \_\_\_\_\_ RX DRUG: \_\_\_\_\_ RX CARD #: \_\_\_\_\_

7. Complete for Insured and all Covered Dependents

FIRST	LAST	SSN	DATE OF BIRTH	INSURANCE BEGIN DATE	INSURANCE END DATE	*
AMARIJAH	BEALS	339-02-8423	01/08/2003			

If additional space is needed, please provide the same information on a separate sheet of paper.  
 PREMIUM FOR INSURED \$ \_\_\_\_\_ PER \_\_\_\_\_ PREMIUM FOR DEPENDENTS \$ \_\_\_\_\_ PER \_\_\_\_\_  
 \* Enter relationship to Policyholder Code (Psyhdr-0, Son-1, Dau-2, Spouse-3, Stepchild-4, Grandchild-5, Other-6)

8. Complete if Dependents were Insured by You Under a Previous Plan (Group Insurance Only)

NAME OF PREVIOUS CARRIER GROUP # BEGIN DATE END DATE  
 STREET CITY ST ZIP

9. Person Completing This Form

SIGNATURE TELEPHONE DATE

PLEASE MAIL TO: IL DEPT OF HEALTHCARE AND FAMILY SERVICES / DIVISION OF CHILD SUPPORT SERVICES  
 3554 Medical Support Unit-COOK PO Box 641097 Chicago IL 60664-1097