IL Dept of Healthcare and Family Services
Division of Child Support Services
PO Box 64900 AIDC50K3
Chicago IL 60664

#200627 017863482#
LAKE REGION MEDICAL
140 E HINTZ RD
WHEELING IL 60090-6044

SEE REVERSE SIDE OF THIS FORM FOR RETURN MAILING INSTRUCTIONS.
Vea el reverso de este formulario con instrucciones para cómo devolver la carta.

DCSS Modification Review Team
PO Box 64900 AIDC50K3
Chicago IL 60664

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USE THIS FORM TO RETURN FORM HFS 3467 IN THE ENVELOPE PROVIDED.
Use este formulario para devolver el Formulario HFS 3467 en el sobre adjunto.

Fold on dotted lines. Insert in return envelope with address showing through window.

Dobelo por las lineas de puntos. Pongalo en el sobre de manera que el nombre y direcci n se vean por la ventanilla.

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IL Dept of Healthcare and Family Services
Division of Child Support Services
DCSS Modification Review Team
PO Box 64900 AIDC50Z3
Chicago IL 60664

Date: DECEMBER 25, 2015

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

RE: TERRY BEALS

EMPLOYER REQUEST FOR INFORMATION

Healthcare and Family Services, Division of Child Support Services requires completion and return of the attached form concerning the above named employee within 15 days of receipt to the address listed at the top of this page. The information provided on the attached form enables the Department to determine the appropriate next steps related to the employee's child support obligation.

Failure to return this form within 15 days could result in a penalty of $100 for each day that the information is not provided to the Department after the 15-day period has expired. You may withhold a fee of up to $20 from this employee's wages for providing the information. The statutory authority for this request, which includes the obligation to respond and the right to a fee is stated in 305 ILCS 5/10 - 3.1.

Even if the employee no longer works for you, please complete and return the attached form and provide the employee's end date, the reason for leaving and any other pertinent information.

Before mailing your response, please fill out your payroll title, sign and date the form (found on the last page of this form).

If you have any questions, please contact DCSS Modification Review Team at (312)803-7253. The Department appreciates your assistance in this matter.

Pamela Lowry

Administrator, Division of Child Support Services

122515 C01739697 060500840 063953152 237P20050183

TO: IL Dept of Healthcare and Family Services
Division of Child Support Services

DCSS Modification Review Team
PO Box 64900
Chicago IL 60664

Custodial Parent: TIANTE LOCKETT	CP RIN: 060500840
Employee Name: TERRY BEALS	Employee SSN: 409-49-5013
NCP RIN: 063953152	Order/Docket No.: 237P20050183
Employer: LAKE REGION MEDICAL	
140 E HINTZ RD	
WHEELING IL 60090-6044	

For the above named employee, please complete and return the following to the address listed above. **If this employee/obligor no longer works for you, proceed to the last page of this form.**

1. Employee/obligor Social Security Number:_____

2. Employee/obligor Mailing Address:

_____;_____,_____,_____ _____
(Street) (City) (St) (Zip) (Tel No)

3. Dates of Employment: From _____ To _____

4. Employee/Obligor Work Location (if different from employer address listed above):

_____;_____,_____,_____ _____
(Street) (City) (St) (Zip) (Tel No)

Employee Name: TERRY BEALS 063953152

Employer Request For Information

If the employee's wages vary from one pay period to the next, please include three months of consecutive pay periods. If there is insufficient room on the form, please complete the information on additional paper and include it with your reply or enclose a printout of the employee/obligors wage and deduction information.

5. Employee/obligor wage/deduction information:

Pay frequency
(Circle one): Weekly Every Other Week Twice Each Month Monthly

Gross Pay	$_____
Number of Exemptions Claimed	$_____
Federal Income Tax	$_____
State Income Tax	$_____
Social Security (FICA)	$_____
Medicare	$_____
Mandatory Retirement	$_____
Union Dues	$_____
Dependent and Individual Health/ Hospitalization Insurance Coverage	$_____
Support Order Payments	$_____

6. List the Child Support Orders for Which Deductions are Being Made:

Order No.	County	Amount Deducted
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Is **Dependent** Health Insurance available through Employer:
YES NO

Policy cost for Dependent Coverage per pay period: $_____

Insurance Company _____

Address _____

Employee Name: TERRY BEALS 063953152

Employer Request For Information

Provide the following information concerning the employee's dependents currently covered under employer-related health insurance:

Name	Birth Date	Name	Birth Date

Check the box and provide the information below (if known) if the employee/obligor no longer works for this employer:

☐ This person no longer works for this employer nor receives periodic income.

Termination date: _____ Last known phone number: _____

Last known address: _____

New employer name: _____

New employer address: _____

CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to such matters therein stated to be on information and belief and as to such matters the undersigned certifies that he/she believes the same to be true.

_____

Signature Title Date

_____

Company Telephone # Federal Employer ID #

IL Dept of Healthcare and Family Services
Division of Child Support Services
DCSS Modification Review Team
PO Box 64900 AIDC50K3
Chicago IL 60664

Date: DECEMBER 25, 2015

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

RE: TERRY BEALS

EMPLOYER REQUEST FOR INFORMATION

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Pamela Lowry

Administrator, Division of Child Support Services

122515 C02721178 043720119 063953152 2014D0051743

TO: IL Dept of Healthcare and Family Services
Division of Child Support Services

DCSS Modification Review Team
PO Box 64900
Chicago IL 60664

Custodial Parent: SHAVONNE JOHNSON	CP RIN: 043720119
Employee Name: TERRY BEALS	Employee SSN: 409-49-5013
NCP RIN: 063953152	Order/Docket No.: 2014D0051743
Employer: LAKE REGION MEDICAL	
140 E HINTZ RD	
WHEELING IL 60090-6044	

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_____; _____, _____, _____ _____
(Street) (City) (St) (Zip) (Tel No)

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Termination date: _____ Last known phone number: _____

Last known address: _____

New employer name: _____

New employer address: _____

CERTIFICATION

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Signature Title Date

Company Telephone # Federal Employer ID #

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Division of Child Support Services
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#200627 O17863481#
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