INFORMATION SHEET AND INSTRUCTIONS FOR REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT

(Do *not* deliver this information sheet to the court clerk.)

Please follow these instructions to complete the *Request and Notice of Hearing Regarding Health Insurance Assignment* (form FL-478) if you do not have an attorney representing you. Your attorney, if you have one, should complete this form. You must file the completed *Request and Notice of Hearing* form and its attachments with the court clerk **within 15 days** after the date your employer gave you a copy of *Application and Order for Health Insurance Coverage (*form FL-470) or *National Medical Support Notice* (form OMB-0970-0222). The address of the court clerk is the same as the one shown for the superior court on the health insurance coverage assignment order. If the local child support agency is not involved in your case, you may have to pay a filing fee. If you cannot afford to pay the filing fee, the court may waive it, but you will have to fill out some forms first and ask the court to waive the fees. For more information about the filing fee and waiver of the filing fee, contact the court clerk or the family law facilitator in your county.

THIS FORM MUST BE FILLED OUT IN TYPE OR PRINTED IN INK.

Front page, first box, top of form, left side: Print your name, address, and telephone number in this box if they are not already there.

Item 1. a–b. You should contact the court clerk's office to ask about procedures for getting a hearing date for this motion.

Item 2. Check this box if you want the court to stop the local child support agency or the other parent from collecting a health insurance premium from your wages or earnings. If you check this box, you must check at least one of the boxes beneath it.

- **a.** Check this box if you are not the person required to pay health insurance premiums in the *Application and Order for Health Insurance Coverage* or *National Medical Support Notice.*
- **b.** Check this box if you believe that health insurance coverage is not available at a reasonable cost.
- **c.** Check this box if you believe the health insurance premium plus the monthly payment in any earnings withholding order are more than half of your total net income each month from all sources.
- **d.** Check this box if you believe the children have reached the legal age of emancipation. Fill in the children's names.
- **e.** Check this box if you were not notified at least 15 days before the date of filing of the application that a health insurance coverage assignment was being sought.
- **f.** Check this box if the court has not ordered you to maintain health insurance.
- **g.** Check this box if you have provided or will provide health insurance for the children, but not through your job-related coverage. This can mean that the other parent or family member is providing, or the child has access to other insurance. Note that governmental medical assistance programs such as MediCal or Healthy Families may not satisfy your obligation to provide health insurance. If you need further information, see your county's family law facilitator or local child support agency.
- **h.** Check this box if you believe that your employer's choice of coverage is inappropriate and explain why.
- **i.** Check this box if you have some other reason that this order should not be enforced and explain why.

You must date this *Request and Notice of Hearing Regarding Health Insurance Assignment*, type or print your name, and sign the form under penalty of perjury. When you sign this form, you are stating that the information you have provided is true and correct. You must also complete the certificate of mailing on page 2 of the form by printing the name and address of the other parties or the attorneys for the other parties in brackets and providing the clerk with a stamped envelope addressed to each of the parties or attorneys for parties. Do not date or sign page 2 of the form. The court clerk will explain to you how to get a court date.

You must file your request within 15 days of receiving the *Application and Order for Health Insurance Coverage* or *National Medical Support Notice* from your employer, unless there's been a change of circumstances and you are using the form to change an ongoing health insurance assignment. You may file your request in person at the clerk's office or mail it to the clerk. In either event, it must be received by the clerk within the 15-day period.

If you need additional assistance with this form, contact an attorney or the family law facilitator in your county. The family law facilitator can help you, for free, with any questions you have about the above information. For more information on finding a lawyer or family law facilitator, see the California Courts Online Self-Help Center at *www.courtinfo.ca.gov/selfhelp.*

NOTICE: Use this form to request a hearing only if you object to the *Application and Order for Health Insurance Coverage* (form FL-470) or *National Medical Support Notice* (form OMB-0970-0222). This form will *not* modify your current support amount. (See "Information Sheet on Changing a Child Support Order" on page 2 of form FL-192.)

Form Approved for Optional Use
Judicial Council of California
FL-478-INFO [New January 1, 2007]

INFORMATION SHEET AND INSTRUCTIONS FOR REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT
(Family Law—Governmental—UIFSA)

Family Code, §§ 3761, 3765, and 3773
www.courtinfo.ca.gov