

STATE OF MICHIGAN 30TH JUDICIAL CIRCUIT INGHAM COUNTY	OBJECTION TO THE NATIONAL MEDICAL SUPPORT NOTICE AND NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE	CASE NO: JUDGE:
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Plaintiff=s name, address and telephone no. Attorney:	vs.	Defendant=s name, address and telephone no. Attorney:
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THIS OBJECTION MUST BE FILED WITH THE FRIEND OF THE COURT LOCATED AT GRADY PORTER BUILDING, PO BOX 40097, 303 W KALAMAZOO ST. LANSING, MI 48901. IF YOU ARE MAILING YOUR OBJECTION TO THE FRIEND OF THE COURT OFFICE, PLEASE USE THE P.O. BOX ONLY. **

**THE FRIEND OF THE COURT IS FEDERALLY MANDATED TO REVIEW ALL CASES INCLUDING
MEDICAID AND MICHILD RECIPIENT(S)**

1. I, _____ object to the **National Medical Support Notice for Health Care Coverage (NMSN)** regarding enrollment of my minor child(ren) issued to my employer.

My employer is/are (list name and address of employer):

- a) _____
- b) _____

2. The **specific reason(s)** for the objection is/are:

_____ The Court Order does not require me to maintain health care coverage
Provide copy of existing Order

_____ Insurance Cost is too much
Provide 3 pay stubs and proof from your employer regarding the cost of insurance premiums

_____ Third-Party Insurance
Provide copy of both sides of insurance cards (medical, dental, optical), name of policy holder and effective date of coverage

****If the requested information and/or documentation is not provided the Objection will not be processed**

Date: _____

Signature of party, Plaintiff /Defendant

*Objections can only be filed by a party to the action and should specifically identify the problems that you have with the National Medical Support Notice and Notice to Withhold for Health Care Coverage. *****You must mail a copy of your completed Objection form to the other party on the case******

CERTIFICATE OF MAILING

I certify that on _____ I mailed a copy of **Objection to National Medical Support Notice Regarding Health Care Coverage** to the opposing party by ordinary mail addressed to their last known address.

Date: _____

Signature