

# National Medical Support Notice (NMSN)

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NMSN consists of four documents and instructions:

- Part A – Notice to Withhold for Health Care Coverage
  - Employer Response
- Part B – Medical Support Notice to Plan Administrator
  - Plan Administrator Response



# National Medical Support Notice

## Part A – Notice to Withhold for Health Care Coverage

- Review the information on the NMSN
- Complete the Employer Response
- Forward Part B to the Plan Administrator if necessary
- Withhold premiums as appropriate
- Determine the limitations on withholding
- Consider the priority of withholding

# National Medical Support Notice – Employer Response

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. The employee is not longer employed (complete the requested information).



# Employer Response - continued

- 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.

## Amounts to Withhold and Remit ?

Withhold for Health Insurance	0.00
Total Amount to Withhold	25.00
Total Amount to Remit	25.00

**PRINT**

**NEW CALCULATION**

**RESET**



# Employer Response - continued

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



# Employer Response - continued

## CONTACT FOR QUESTIONS

Plan Administrator Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Employer Name: \_\_\_\_\_

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

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

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

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

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

Federal EIN: \_\_\_\_\_

(if not provided on Page 1 of this Notice)

Date: \_\_\_\_\_



# National Medical Support Notice

## Part B – Medical Support Notice to Plan Administrator

### Plan Administrator:

- Enrolls the child and notifies the employer of the amount of the premium
- Notifies the employee and the custodial parent of the child's enrollment
- Notifies the child support agency





# National Medical Support Notice - Plan Administrator Response

## 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 # \_\_\_\_\_ (to be completed by the issuing agency)

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.



Department of  
Social Services  
Human Resources Administration  
Department of Homeless Services

Office of Child  
Support Services



Office of Temporary  
and Disability Assistance

# Plan Administrator Response - continued

2. The participant (employee) and alternate recipients(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 the date of receipt of the 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.



# Plan Administrator Response - continued

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.

# Plan Administrator Response - continued

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 Response - continued

Plan Administrator or Representative:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_



# Questions?

Employer Helpline: (888) 208-4485 or (800) 846-0773

Child Support Website: [childsupport.ny.gov](https://childsupport.ny.gov)

Mary Hans: [mary.hans@otda.ny.gov](mailto:mary.hans@otda.ny.gov)



Department of  
Social Services  
Human Resources Administration  
Department of Homeless Services

Office of Child  
Support Services



Office of Temporary  
and Disability Assistance