Approved, SCAO

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	EMPLOYER'S DISCLOSURE OF HEALTH INSURANCE AND/OR INCOME INFORMATION	CASE NO.

Friend of the court address **Telephone no.**

NOTICE TO EMPLOYER

Under Michigan law, you are required to provide information according to MCL 552.518. Return this completed form to the friend of the court at the above address. **Complete both sides and sign.**

1. Employee name	2. Address	
3. Social security number	4. Employer name	5. Employer federal identification no.
6. Employer address		

7. Hourly base pay	8. Shift premium	9. COLA	10. Avg. overtime $ /week	11. W-4 Exemp.	12. Reg. work hours /week	13. Pay period (weekly, etc.)
14. No. weeks paid this yr.	15. Date hired	16. Date of term. (if appl.)	17. Reason for leaving	18. Is this person receiving unemployment benefits? ☐ Yes ☐ No		

Calculate year-to-date figures as of last pay period.

19. INCOME	Reg. Earnings (incl. shift prem. and COLA)	Overtime	Commissions and Bonuses	Pension and Longevity	Profit Sharing	Other (explain)	Gross	Deferred income in addition to gross
Year to Date								
Last Calendar Year								

20. RETIREMENT CONTRIBUTIONS	Mandatory Employee	Voluntary Employee
Year to Date		
Last Calendar Year		

21. OTHER INCOME	Disability	Workers Comp.	Sick Pay	SUB Pay
Year to Date				
Last Calendar Year				

Disability carrier

Worker's compensation carrier

22. WITHHOLDING	Federal Income Tax	F.I.C.A.	State Income Tax	Local Income Tax	Mandatory Professional or Union Dues	Alimony and Child Support	Mandatory Withholding (explain)
Year to Date							
Last Calendar Year							

23. Check all that apply

- ☐ Employer offers a medical flexible spending account.
- ☐ Dependent insurance not offered to employees.
- ☐ Dependent insurance ☐ medical ☐ dental ☐ optical is offered to the employee but the employee has not enrolled. (Attach information regarding dependent coverages and cost.)
- ☐ Employee will be eligible for dependent insurance. Date available: _____ (Attach information regarding dependent coverages and cost.)
- ☐ Employee has enrolled for dependent insurance. (Complete items 24 through 29. If you need additional space, use the space below.)

24. Medical insurance company name, address, telephone no. Policy no. and Group no.	25. Dental insurance company name, address, telephone no. Policy no. and Group no.
26. Optical insurance company name, address, telephone no. Policy no. and Group no.	27. Other insurance (i.e. prescription, mental health)

28. What dependent coverage is offered? Specify cost to employee ☐ employee only ☐ individual plus one ☐ per family

☐ Medical $ _____ per _____ ☐ Dental $ _____ per _____ ☐ Optical $ _____ per _____

29. What dependents of employee are covered?

Name	DOB	Relationship	Effective Date of Coverage Medical	Dental	Optical

Date	Name of person preparing form (type or print)	Telephone no.

The information obtained from this disclosure form will be treated as confidential and will not be used or released except for purposes of administering, enforcing, and complying with state and federal laws governing child support.

Name of contact (type or print)	Title	Telephone no.	Date

Use this space for any necessary explanations.