**[Date]**

|  |  |
| --- | --- |
| **[Participant]**  **[Address]** | **[Alternate Recipient (Child) or Designate Named in QMCSO]**  **[Address]** |

Dear **[participant]** and **[alternate recipient(s) or designate]**:

This is to advise you that we have reviewed the **[court order]** or **[****National Medical Support** **Notice]** received on **[date]**, relating to the coverage of **[alternate recipient(s)]** under the **[enter name of group health plan(s)]** as a child **(children)** of **[participant]**. We have determined this **[court order]** or **[Notice]** to be a qualified medical child support order (QMCSO) as defined under federal law.

***[Include one of the two alternative paragraphs below. The first paragraph is included if the child is not already enrolled as a dependent under the plans. The second paragraph is included if the child is already enrolled as a dependent.]***

***[Alternate 1:]***

Coverage for **[alternate recipient(s)]** will begin as of the ***[describe enrollment dates-e.g., first day of the month]*** after a completed enrollment form has been filed with the plan administrator (employer) and the following additional conditions have been met: ***[describe any other conditions for enrollment, such as a waiting period to be completed by the participant]. [If applicable, address selection of coverage options and any default options under the group health plan(s); enclose information about the coverage options****.]*

***[Alternate 2:]***

Our records indicate that **[alternate recipient(s)] [is already enrolled as a dependent]** ***or*** **[are already enrolled as dependents]** of **[participant]** under the terms of the **[enter name of group health plan(s)]**, and there will be no interruption in coverage as a result of the **[court order]** or **[Notice]**.

Coverage for **[alternate recipient(s)]** will end at the time stated in the **[court order]** or **[Notice]** or, if sooner, when otherwise provided under the terms of the enter name of group health plan**(s)**. For example, coverage will end when **[participant]** or **[alternate recipient(s)]** cease**(s)** to be eligible (subject to any right the alternate recipient may have to elect continuation coverage under COBRA or other applicable law).

You (or your attorney) have 30 days after the date of this letter to submit written comments regarding our determination. You should direct your comments to **[enter name of employer and contact]** at the following address, **[address]**. If no comments are received within this period, this determination will become final. If you do not intend to comment, please notify us of your intentions in writing. If comments are received during this period, the **[enter name of employer]** will consider them and notify you of its final determination.

Please keep us informed of your current address. In addition, please advise us if there is anyone else who should be receiving copies of correspondence relating to any benefits that may be available to **[alternate recipient(s)]**. Your cooperation is appreciated.

Sincerely,

**[Name]**

**[Title]**

**[Employer Name]**

**[enter name of group health plan(s)]**

Enclosures (SPD(s) and enrollment materials)

cc: **[Participant's Attorney, if any]**

**[Alternate Recipient's Attorney, if any]**

**[State Agency, if any]**