Record of Completed QMCSO Procedures

Initial Response to Receipt of Order or Notice

Employee's Name _____ Social Security Number _____

Alternate Recipient(s):

	Name	Date of Birth	Address	Social Security Number
1				
2				
3				
4				

Date order or notice received _____ Date acknowledgment letter/procedures sent _____

Assessment of Order or Notice (attach completed checklist)

Is order a National Medical Support Notice? ☐ Yes ☐ No

Is legal counsel's review necessary? ☐ Yes ☐ No

Date referred to legal counsel _____

Date of legal counsel review _____ Reviewed by _____

Date checklist completed _____ Completed by _____

Plan(s) to which order applies

☐ Medical
☐ Dental
☐ Vision
☐ Health FSA
☐ Health Reimbursement Account
☐ Other

Representative(s) designated to receive copies of notices sent to alternate recipient(s):

_____

_____

_____

Determination: ☐ QMCSO ☐ Not a QMCSO (reasons to be noted on checklist)

Sample Record of Completed QMCSO Procedures

Response to Parties

Date parties notified of employer's determination _____

Any response from parties? _____ Date received _____

Notes on further action:

_____

_____

Steps Taken Pursuant to QMCSO

Is an additional contribution required for coverage of alternate recipient(s)? ☐ Yes $_____ ☐ No

Has determination been made that withholding the additional contribution does not exceed applicable state and federal wage withholding limitations? ☐ Yes ☐ No

If withholding limitations would prevent the withholding of the additional contribution, have parties been notified? ☐ Yes ☐ No

Date of notification _____

Any response received? ☐ Yes ☐ No Date received _____

Is employee currently enrolled in the Plan(s)? ☐ Yes ☐ No

Date employee enrolled in Plan(s) _____

Is/are alternate recipient(s) currently enrolled as dependent(s) in the Plan(s)? ☐ Yes ☐ No

Date alternate recipient(s) enrolled in Plan(s) _____

Person(s) to whom it is expected that benefit reimbursements may be made:

Name _____

Address _____

_____

Relationship to alternate recipient(s):

- ☐ Employee parent
- ☐ Other parent
- ☐ State agency
- ☐ Legal guardian
- ☐ Other: _____

Date alternate recipient(s) added to mailing list for plan information (SPDs, SARs, etc.): _____

Sample Record of Completed QMCSO Procedures

Person(s) to whom plan information should be furnished following enrollment of alternate recipient(s):

Name _____

Address _____

_____

Insurance carrier notified of approved QMCSO/NMSN? ☐ Yes ☐ No

Date of notification _____ Notified by _____