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.

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 the purposes of administering, enforcing, and complying with state and federal laws governing child support.

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

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

7. Check all that apply
- ☐ Employer offers a medical flexible spending account.
- ☐ Dependent insurance not offered to employees. (Skip to item 14.)
- ☐ 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 8 through 13. If you need additional space, use the other side)

8. Medical insurance company name, address, telephone no. Policy no. and Group no.	9. Dental insurance company name, address, telephone no. Policy no. and Group no.
10. Optical insurance company name, address, telephone no. Policy no. and Group no.	11. Other insurance (i.e. prescription, mental health)

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

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

13. What dependents of employee are covered?

Name	DOB	Relationship	Effective Date of Coverage: Medical	Dental	Optical

14. Hourly base pay	15. Shift premium	16. COLA	17. Avg. overtime $ /week	18. W-4 Exemp.	19. Reg. work hours /week	20. Pay period (weekly, etc.)

21. No. weeks paid this yr.	22. Date hired	23. Date of term. (if appl.)	24. Reason for leaving	25. Is this person receiving unemployment benefits? ☐ Yes ☐ No

☐ **Complete the Income Information on the other side.**

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

26. 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								

27. RETIREMENT CONTRIBUTIONS	Mandatory Employee	Voluntary Employee	Employer
Year to Date			
Last Calendar Year			

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

Disability carrier

Worker's compensation carrier

29. 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							

Return this completed form to the friend of the court at the address on the other side.

Use this space for any necessary explanations from the other side.