Approved, SCAO

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

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

The information obtained will be treated as confidential and shall 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

Complete items 7, 8, and 9 if insurance is **available** to employee.

7. Medical insurance company name, address, telephone no. Policy number	8. Dental insurance company name, address, telephone no. Policy number

9. Optical insurance company name, address, telephone no. Policy number	10. What dependent coverage is automatically available? ☐ Medical ☐ Dental ☐ Optical

11. What dependent coverage is available by payment of an additional premium? Specify cost to employee ☐ per individual ☐ per family
☐ Medical _____ per _____ ☐ Dental _____ per _____ ☐ Optical _____ per _____

12. What dependents of employee are covered?

Name	DOB	Relationship	Effective Date of Coverage Medical	Dental	Optical

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

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

Calculate year to date figures as of last pay period.

25. 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								

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

Disability carrier

Worker's compensation carrier

27. 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							

Sign and return to the friend of the court address listed above. Use other side if necessary. See the notice on the other side.

Date | Name and signature of person preparing form | Telephone no.

NOTICE TO EMPLOYER

Pursuant to Michigan law, you are required to provide information relative to the custodial or absent parent as follows:

Sec. 18.(1) Subject to subsection (3) and (4), upon the request of the office of the friend of the court, any employer or former employer of a parent as defined in section 1 of the office of child support act, 1971 PA 174, MCL 400.231, who is or was employed as an employee or independent contractor, shall provide the following information relative to the custodial parent or absent parent:

(a) Full name and address.

(b) Social security number (unless the parent is exempt under state or federal law).

(c) Date of birth.

(d) Amount of wages earned by or other income due the custodial parent or absent parent. Both net and gross income shall be reported, regardless of the method of payment.

(e) The following information concerning the person's current and former employment status: whether or not the custodial parent or absent parent is currently employed, laid off, or on sick, disability, or other leave of absence, or retired and the amount of income due from an employment-related benefit plan, if any.

(f) Dependent health-care coverage available to the custodial parent or absent parent as a benefit of employment.

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

Approved, SCAO

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	EMPLOYER'S DISCLOSURE OF HEALTH INSURANCE INFORMATION	COURT CASE NO.

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

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

Name of FOC employee (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. IV-D case no.

Complete items 8, 9, and 10 if insurance is **available** to employee.

8. Medical insurance company name, address, telephone no. Policy number	9. Dental insurance company name, address, telephone no. Policy number

10. Optical insurance company name, address, telephone no. Policy number	11. What dependent coverage is automatically available? ☐ Medical ☐ Dental ☐ Optical

12. What dependent coverage is available by payment of an additional premium? Specify cost to employee ☐ per individual ☐ 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

Sign and return to the friend of the court address listed above. Use other side if necessary. See the notice on the other side.

Date | Name and signature of person preparing form | Telephone no.