FL-475

PETITIONER/PLAINTIFF:	CASE NUMBER:
RESPONDENT/DEFENDANT:	

EMPLOYER'S HEALTH INSURANCE RETURN

1. Name of parent employee:

2. Home address of absent parent employee:
   ☐ Not known

3. ☐ The employee has *no* insurance policies for health care, vision care, or dental care through this employment.

4. ☐ The employee has the following insurance policies covering health care, vision care, and dental care:

Company	Type of policy	Policy No.	Persons insured

Date:

(TYPE OR PRINT NAME OF EMPLOYER)

(SIGNATURE OF EMPLOYER)

Address:

Telephone No.:

5. Return this completed return to the following local child support agency within 30 days *(name and address of local child support agency):*

If any insurance coverage lapses, complete the notice below and return a copy to the same local child support agency.

NOTICE OF LAPSE IN HEALTH INSURANCE

6. The health insurance listed on the *Employer's Health Insurance Return* above has
   ☐ lapsed ☐ terminated **for** *(check one):*
   a. ☐ all persons insured, for the following reason *(specify):*

   b. ☐ the following person *(name):* for the following reason *(specify):*

Date:

(TYPE OR PRINT NAME OF EMPLOYER)

(SIGNATURE OF EMPLOYER)

Address:

Telephone No.:

Form Adopted for Mandatory Use
Judicial Council of California
FL-475 [Rev. January 1, 2003]

Print this Form

Family Code, §§ 3771, 3772
www.courtinfo.ca.gov