Approved, SCAO

Original - Court
1st copy - Obligor

2nd copy - Requesting party
3rd copy - FOC file

STATE OF MICHIGAN 49th JUDICIAL CIRCUIT Osceola COUNTY	COMPLAINT FOR ENFORCEMENT OF HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court address
301 West Upton, Reed City, MI 49677

Telephone no.
(231) 832-6131

Plaintiff

v

Defendant

TO: Obligor's name and address

Notice to Obligor:
Under MCL 552.511a, the friend of the court has been asked to enforce the health care expenses described below. Unless you file a written objection with the friend of the court within 21 days of the date provided in MCL 552.511a, the expenses will be added to your support account as a health care support arrearage for enforcement and must be paid ☐ in full by _____.
☐ $_____ per month, except that the full balance will be subject to immediate enforcement.
If you timely file a written objection in the manner required, a hearing will be set to resolve the health care complaint.

I certify that on this date I mailed a copy of this complaint to the obligor by ordinary mail to the obligor's last known address.

Date

Friend of the court/Authorized representative

Requesting Party's Statement:

I request the friend of the court to enforce health care expenses. Attached is the request for Health Care Expense Payment (including all supporting documents) given to the obligor. **I declare that:**

1. I requested payment within 28 days of the date notified of the balance due after insurance payments.

2. This request is for expenses that are more than the minimum amount my order requires for enforcement.

3. This complaint is
   ☐ within 6 months after the date of the insurer's final denial of coverage for the expense.
   ☐ within 1 year of the date the expense was incurred.
   ☐ within 6 months after the obligor's default of an agreement to repay (copy of agreement attached).

4. As of this date, the expense information in the attached Request for Health Care Expense Payment is true except as follows:

   Since the date I mailed the Request for Health Care Expense Payment to the obligor, the obligor paid $_____

   for _____ and _____.
   Name(s) of child(ren) Name(s) of medical provider(s)

I declare that the above statements are true to the best of my information, knowledge, and belief.

Date

Signature