STATE OF MICHIGAN 45TH JUDICIAL CIRCUIT ST. JOSEPH COUNTY	COMPLAINT AND NOTICE FOR HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court, 920 W Michigan Ave, Three Rivers, MI 49093 (269)467-5570

Plaintiff	V	Defendant

TO: Payer's Name and Address

COMPLAINT

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 payer. **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 annual ordinary medical amount that can be collected as specified in the support order.
3. This complaint is
   - ☐ within six months after the date of the insurer's final denial of coverage for the expense.
   - ☐ within one year of the date the expense was incurred.

_____ _____

Date Signature

DO NOT WRITE BELOW THIS BOX – FOR FRIEND OF THE COURT USE ONLY

NOTICE

The Friend of the Court has been asked to enforce health care expenses. Unless you file a written objection with the Friend of the Court within 21 days of the date this notice is sent, the expenses will be added to your support account as a health care support arrearage for enforcement.

Total medical cost not paid by insurance $_____

Annual ordinary health care amount $_____

Amount to be divided between parties $_____

Percent to be paid by Payer _____%

Total Amount owed by Payer $_____,

which must be paid $_____ 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.

CERTIFICATE OF MAILING

I certify that on this date I served a copy of this complaint on the parties or their attorneys by first-class mail addressed to their last-known addresses as defined in MCR 3.203.

_____ _____

Date Friend of the Court/Authorized representative