

Iowa Department of Human Services
EMPLOYER INSURANCE NOTIFICATION

Date Prepared: _____
Case Number: _____

Employee Name: _____
Soc Sec Number: _____

Dear Employer:

We learned that the employee named above is no longer working for your company. Please provide as much information as you can about the health insurance coverage the employee (obligor) provided for the children while employed by your company. Indicate below the date the health insurance ended (or will end). Return this form to our office within 10 days.

Last date of employment for the above-named employee : _____
The health insurance coverage has, or will end on : _____
Is the above-named individual continuing health insurance coverage? Yes No

If yes, please indicate the type of coverage:

- COBRA Union agreement An agreement with the employer
 Obligor paying own premium Other options

Please list the person CSRU may contact concerning continuing coverage:

Name: _____
Insurance Company: _____

Phone Number: _____

Return this form to the address provided below.

Child Support Recovery Unit

