Approved, SCAO

Original - Friend of the court
1st copy - Obligor
2nd copy - Requesting party

STATE OF MICHIGAN 11th JUDICIAL CIRCUIT Schoolcraft COUNTY	COMPLAINT AND NOTICE FOR HEALTH-CARE EXPENSE PAYMENT	CASE NO.

Court address 300 Walnut Street, Manistique, MI 49854

Telephone no. (906) 341-3650

Plaintiff

v

Defendant

TO: Obligor'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 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 annual ordinary medical amount that can be collected as specified in the support order.
   - ☐ health-care expenses that have been incurred by the payer of support.
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.
   - ☐ within six 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)

Date _____ Signature _____

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 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.

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 _____