

Office of the Attorney General
MEDICAL SUPPORT UNIT
P.O. BOX 1328
AUSTIN, TX 78767-13285
Toll-Free (800) 522-2421
Fax (855) 329-6676



CHILD SUPPORT DIVISION

Bar code Area (w/ FSN)
FS#

Date:
Custodial Parent
Non-Custodial Parent:
Attorney General Case #
Cause #

HEALTH INSURANCE STATUS CHANGE FORM

Employers are required to notify the Office of the Attorney General of a change of status of an employee [Texas Family Code, 154.187 and 158.211]. Please keep this form for use as needed. If there is a change in the employee's health insurance or employment status, please complete this form and return it to:

Medical Support Unit
P.O. Box 1328
Austin, TX 78767-1328

If you have any questions, please call (800) 522-2421. For information about providing this information via the Internet, please visit www.employer.texasattorneygeneral.gov.

Obligor:

Social Security Number:

Date of occurrence: _____

Attorney General Case #:

This is to advise of a change in employment status between the above obligor and this employer

The obligor is no longer employed by this employer; income withholding will stop on _____
(Notification of withholding interruption must be made within 7 days.)

The obligor's last known home address:

The obligor's new employer name and address if known:

Telephone Number: _____

Health insurance coverage has lapsed.

Notification of insurance interruption must be within 15 days of occurrence.

If the obligor is eligible for health insurance conversion privileges (COBRA), please enclose information.

Signature of Person Completing Form

Date Form Completed

Position/Title

(Area Code) Telephone Number

Internet/Web Address

