ALL PRO QDRO, LLC
P.O. Box 1600
Livingston, N.J. 07039
Phone 973-716-9777 * Fax 973-716-9877
Web: www.allproqdro.com

CHECK LIST FOR QMCSO
Qualified Medical Child Support Order

The following data is required for the preparation of an Order against a Health Benefit Plan. Upon completion, please sign the bottom of the form as requested and enclose the appropriate fee. In the event you do not have all of the data presently available, you may send us the information you have, together with the payment of our fee, and we will advise you if additional documents are necessary.

1. Provide basic factual information regarding the case:

Plaintiff / Petitioner: _____
Is this individual the husband or wife? _____

Defendant / Respondent:_____

Is this individual the husband or wife? _____

State:_____ County:_____

Docket # / Case #:_____

Are the parties using an attorney to review and file this QDRO?

Yes - utilizing an attorney _____

No - proceeding pro se _____

If an attorney is being utilized, provide the following information for the attorney. If proceeding Pro se, provide the following information for yourself.

Attorney for the Plaintiff/Petitioner or Pro se Plaintiff/Petitioner:

Name:_____

Address:_____

_____

Phone Number:_____

E-mail address (REQUIRED):_____

Attorney for the Defendant/Respondent or Pro se Defendant/Respondent:

Name:_____

Address:_____

Phone Number:_____

E-mail address (REQUIRED):_____

NOTE: Most communications with parties will be via e-mail.

2. **Who will be filing the Order with the Court:** _____

If an attorney is filing provide name and NJ attorney identification number as required by NJ Court Rule 1:4-1(b):

Attorney name:_____

Attorney ID#:_____

3. **Which party's insurance is to attached by this Order?**

Husband _____ **Wife** _____
This individual will hereinafter be designated as the Participant.

4. **Provide the following regarding the Participant (Employee):**

Name of Participant. _____

Date of birth. _____

Last known mailing address. _____

_____

Last four digits of Social Security Number. _____
(Please note a full social security number may be requested by the Plan)

Current Employer._____

Employment Status. _____

5. **Provide the following regarding the Alternate Recipients (Dependent children):**

Name of Alternate Recipient #1._____

Date of birth. _____

Last known mailing address. _____

_____

Last four digits of Social Security Number. _____
(Please note a full social security number may be requested by the Plan)

Name of Alternate Recipient #2._____

Date of birth. _____

Last known mailing address. _____

_____

Last four digits of Social Security Number. _____
(Please note a full social security number may be requested by the Plan)

Name of Alternate Recipient #3._____

Date of birth. _____

Last known mailing address. _____

_____

Last four digits of Social Security Number. _____
(Please note a full social security number may be requested by the Plan)

6. **Provide the exact legal name of the Insurance Carrier and all identifying information.**

   Name of Plan Sponsor._____

   Identification number of Plan. _____

   Name and address of Insurance Carrier. _____

7. **Provide the name and telephone number of the Benefits Manager (Current Employer) and the Insurance Company.**

   Benefits Manager._____

   Insurance Company._____

8. **Advise the date the Participant joined the plan. _____**

9. **Is the Participant still actively employed with the Plan Sponsor?_____**

DOCUMENTS REQUIRED:

Please provide:

____ A copy of the relevant section of the Marital Settlement Agreement specifying the section related to the Domestic Relations Order or pension.

____ A copy of the first page of the original Complaint.

____ A copy of the Judgment of Divorce.

____ A copy of the Insurance Carrier information and/or a copy of the Participant's insurance card. Please be sure to include the name and telephone number of a contact person for the Plan.

SIGNATURE:

My signature below confirms that the information provided above is accurate and complete to the best of my knowledge. I have not intentionally provided any false or misleading information nor have I purposefully omitted any information. My signature below also confirms my request that All Pro QDRO prepare a Qualified Medical Child Support Order in this matter and that I accept the fees as indicated. I understand that $100 of the below stated fee is NON-REFUNDABLE as file set up fee.

Signature: _____

Date:_____

METHOD OF PAYMENT

____ Preparation of each QDRO at $700.00.

___ Expedited Fee $150 per QDRO. (Please note if requesting expedited service only a credit card or a law firm check will be accepted for payment)

Total amount: $_____

____ Enclosed is my check made payable to All Pro QDRO, LLC.

____ My credit card information is provided below

Credit Card Type: **Visa, Mastercard, Discover, American Express**

Credit Card Number: _____

Security Number (cvv): _____
(This is a 3 digit # for Visa, M/C, Discover and a 4 digit # for Amex)

Expiration Date: _____

Cardholder's name: _____

Billing street address: _____

Billing Zip Code: _____

Amount to be Charged: **$ _____**

Telephone Number: _____

Checklist and documents can be mailed to our postal address or emailed to info@allproqdro.com