State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

Under Internal Revenue Service (IRS) tax code Section 125, guidelines are provided for a Qualifying Life Event (QLE) status change. Employees must upload supporting documents to eBenefits or provide them to their Health Benefits Representative (HBR) to verify the QLE, in accordance with State Health Plan rules. This process must be completed within 30 days of the QLE or within 60 days of becoming eligible for or losing eligibility for Medicaid or the Children's Health Insurance Program (CHIP).

Additionally, employees must provide documentation to verify a dependent's eligibility when adding them to the Plan due to a New Hire event, a QLE, or during Open Enrollment. For a list of acceptable documents, please refer to the chart on page 2.

QUALIFYING LIFE EVENTS	REQUIRED DOCUMENTATION FROM EMPLOYEE
ADOPTION	Refer to chart on page 2
BIRTH	
COURT ORDER *(may only be used to add dependents; cannot be used to drop dependents)*	
DEATH of a Dependent	Death Certificate / Obituary
Dependent GAINS Medicaid COVERAGE	Written notification showing effective date of Coverage or ID card with effective date.
DIVORCE	Divorce Decree / Judgment
ENROLL in 12-MONTH REDUCTION in FORCE (RIF)	See your HBR to process event. HBR must submit an exception and materials provided by member to demonstrate the cost increase. Refer to chart on page 2 for additional requirements to add a dependent.
GUARDIANSHIP or LEGAL CUSTODY of a Child	Refer to chart on page 2
LEGAL SEPARATION	Separation Agreement or Affidavit (sworn, notarized statement) to validate legal separation.
LOSS OF MEDICAID or CHIP COVERAGE	Written notification showing termination date and current notification date. Refer to chart on page 2 for additional requirements to add a dependent.
LOSS OF OTHER COVERAGE	Certificate of creditable coverage or written notification from employer listing affected members and the effective date. Refer to chart on page 2 for additional requirements to add a dependent. If you or your dependents change your country of permanent residence by moving to or from the U.S., you must provide a signed written statement, along with proof of the date of the change. *Note: Losing individual coverage does not qualify as a qualifying life event if you voluntarily drop it, fail to pay premiums, or do not provide required documentation when requested.*
MARRIAGE (Employee)	Refer to chart on page 2
MILITARY LEAVE	See your HBR to process event. Requires copy of Active Duty documentation, including date active duty begins.
NEWLY ELIGIBLE for COVERAGE	Refer to chart on page 2 for additional requirements to add a dependent.
NOW ELIGIBLE for OTHER COVERAGE	Written notification from employer, Medicaid or CHIP showing effective date or Insurance Card with an effective date and notification date. If you or your dependents change your country of permanent residence by moving to or from the U.S., you must provide a signed written statement, along with proof of the date of the change.
RETURN from FAMILY and MEDICAL LEAVE (FMLA)	Refer to chart on page 2 for additional requirements to add a dependent.
RETURN from LEAVE of ABSENCE	Refer to chart on page 2 for additional requirements to add a dependent.
RETURN from MILITARY LEAVE	Requires copy of Active Duty documentation, including date active duty ends. Refer to chart on page 2 for additional requirements to add a dependent.
SIGNIFICANT CHANGE in COST of EXISTING COVERAGE	See your HBR to process event. HBR must submit an exception and materials provided by member to demonstrate the cost increase. See benefit booklet for details. Refer to chart on page 2 for additional requirements to add a dependent.

State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

DEPENDENT ELIGIBILITY	REQUIRED DOCUMENTATION FROM EMPLOYEE

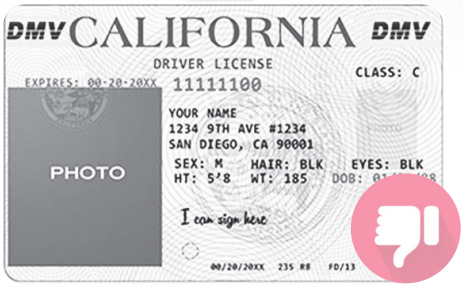
LEGAL MARRIED SPOUSE
Defined as legally married spouse, includes same and opposite gender spouses.
	Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A, or 1040EZ) as filed with the IRS listing the spouse (may be joint or separate as long as the spouse is listed)
	OR
	Official Marriage Certificate** **PLUS** one of the following to show current joint tenancy:
	• Current joint lease or lease showing residency
	• Current joint of one of the below, or two separates of any of the below showing the same address, one listing the employee and the other listing the spouse:
	  • Monthly utility bill or financial statement
	  • Current year's property/vehicle tax or registration bill
	  • Current insurance statement or bill
	  • Designation of the spouse as a primary beneficiary on the employee's life insurance or retirement benefits and listing the primary residence

BIOLOGICAL CHILD UNDER the AGE of 26 *Defined as your biological child, includes child of same gender spouse.*	Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A, or 1040EZ) as filed with the IRS listing the child as a dependent **OR** • Birth Certificate or Mother's Copy with subscriber's name listed as parent • Verification of Facts within 6 months of birth
STEPCHILD UNDER the AGE of 26 *Defined as your stepchild.*	Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A, or 1040EZ) as filed with the IRS listing the child as a dependent **OR** • Birth Certificate or Mother's Copy with subscriber's name listed as parent **AND** Marriage Certificate (indicating employee's spouse is married to employee) • Verification of Facts within 6 months of birth
ADOPTED CHILD UNDER the AGE of 26 *Defined as a child you have legally adopted, or has been placed with you for adoption or in anticipation of legal adoption.*	Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A, or 1040EZ) as filed with the IRS listing the child as a dependent **OR** • International adoption papers from the country of adoption • Official adoption agreement from adoption agency showing intent to adopt the dependent
FOSTER CHILD UNDER the AGE of 26 *Defined as your foster child or child placed with you for foster care.*	Official State Agreement for placement specific to the dependent being added
CHILD UNDER the AGE of 26 for whom the Subscriber is COURT-APPOINTED GUARDIAN *Defined as a child for whom the subscriber has become the court-appointed guardian or has been awarded legal and physical custody by a valid court order.*	Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A, or 1040EZ) as filed with the IRS listing the child as a dependent **OR** Court documents signed by a judge verifying legal custody of the child
CHILD UNDER the AGE of 26 for whom the Plan has received a QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) *Defined as any recognized child you are required to cover under the Plan due to a QMCSO.*	Court documents signed by a judge Medical support orders issued by a State

**Most recent tax form from the previous year. If unavailable, the year prior will be accepted with a letter indicating you have an extension.*
***Employees married less than a year are able to submit their marriage certificate only.*

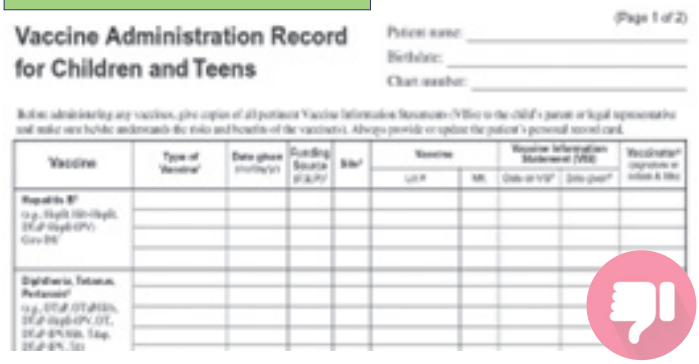
State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

UNACCEPTABLE DOCUMENTATION FOR DEPENDENTS:



HOSPITAL BIRTH CERTIFICATE

IMMUNIZATION RECORDS



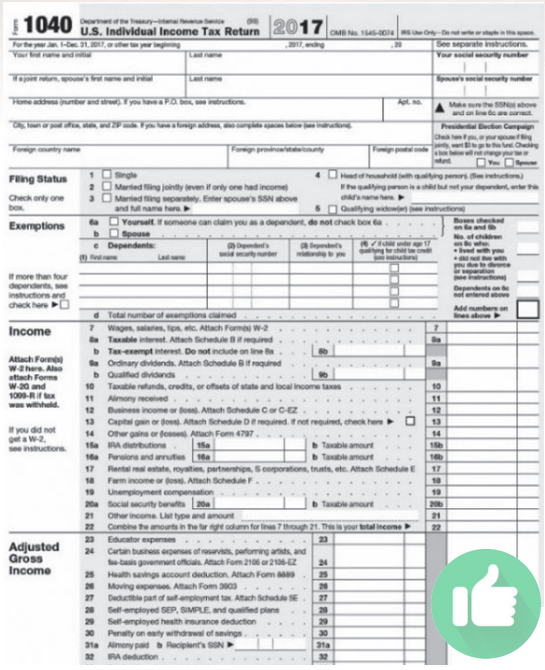
PATERNITY RESULTS

BIRTH CERTIFICATE APPLICATION

State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

ACCEPTABLE DOCUMENTATION FOR DEPENDENTS:

1040 TAX FORM


Form 1040 Department of the Treasury—Internal Revenue Service (99) U.S. Individual Income Tax Return 2017 OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2017, or other tax year beginning , 2017, ending , 20 See separate instructions.

Your first name and initial | Last name | Your social security number

If a joint return, spouse's first name and initial | Last name | Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. Apt. no. Make sure the SSN(s) above and on line 6c are correct.

City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below (see instructions). Presidential Election Campaign

Foreign country name | Foreign province/state/county | Foreign postal code

Filing Status — Check only one box.
1 ☐ Single
2 ☐ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here.
4 ☐ Head of household (with qualifying person). (See instructions.) If the qualifying person is a child but not your dependent, enter this child's name here.
5 ☐ Qualifying widow(er) (see instructions)

Exemptions
6a ☐ Yourself. If someone can claim you as a dependent, do not check box 6a
b ☐ Spouse
c Dependents: (1) First name Last name | (2) Dependent's social security number | (3) Dependent's relationship to you | (4) ✓ if child under age 17 qualifying for child tax credit (see instructions)
If more than four dependents, see instructions and check here ☐
d Total number of exemptions claimed
Boxes checked on 6a and 6b | No. of children on 6c who: • lived with you • did not live with you due to divorce or separation (see instructions) | Dependents on 6c not entered above | Add numbers on lines above

Income — Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld. If you did not get a W-2, see instructions.
7 Wages, salaries, tips, etc. Attach Form(s) W-2
8a Taxable interest. Attach Schedule B if required
b Tax-exempt interest. Do not include on line 8a
9a Ordinary dividends. Attach Schedule B if required
b Qualified dividends
10 Taxable refunds, credits, or offsets of state and local income taxes
11 Alimony received
12 Business income or (loss). Attach Schedule C or C-EZ
13 Capital gain or (loss). Attach Schedule D if required. If not required, check here ☐
14 Other gains or (losses). Attach Form 4797
15a IRA distributions | b Taxable amount
16a Pensions and annuities | b Taxable amount
17 Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E
18 Farm income or (loss). Attach Schedule F
19 Unemployment compensation
20a Social security benefits | b Taxable amount
21 Other income. List type and amount
22 Combine the amounts in the far right column for lines 7 through 21. This is your total income

Adjusted Gross Income
23 Educator expenses
24 Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ
25 Health savings account deduction. Attach Form 8889
26 Moving expenses. Attach Form 3903
27 Deductible part of self-employment tax. Attach Schedule SE
28 Self-employed SEP, SIMPLE, and qualified plans
29 Self-employed health insurance deduction
30 Penalty on early withdrawal of savings
31a Alimony paid b Recipient's SSN
32 IRA deduction

TAX FORM SIGNATURE PAGE


Form 8879 IRS e-file Signature Authorization 2017

Submission Identification Number (SID)

Taxpayer's name | Social security number

Spouse's name | Spouse's social security number

Part I Tax Return Information — Tax Year Ending December 31, 2017 (Whole dollars only)
1 Adjusted gross income (Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 4; Form 1040NR, line 37)
2 Total tax (Form 1040, line 63; Form 1040A, line 35; Form 1040EZ, line 12; Form 1040NR, line 61)
3 Federal income tax withheld from Form(s) W-2 and 1099 (Form 1040, line 64; Form 1040A, line 40; Form 1040EZ, line 7; Form 1040NR, line 62a)
4 Refund (Form 1040, line 76a; Form 1040A, line 46a; Form 1040EZ, line 13a; Form 1040-SS, Part I, line 12e; Form 1040NR, line 73a)
5 Amount you owe (Form 1040, line 78; Form 1040A, line 50; Form 1040EZ, line 14; Form 1040NR, line 74)

Part II Taxpayer Declaration and Signature Authorization (Be sure you get and keep a copy of your return)

Taxpayer's PIN: check one box only
☐ I authorize ____ to enter or generate my PIN
as my signature on my tax year 2017 electronically filed income tax return.
☐ I will enter my PIN as my signature on my tax year 2017 electronically filed income tax return. Check this box only if you are entering your own PIN and your return is filed using a Practitioner PIN method. The ERO must complete Part III below.
Your signature ▶ Date ▶

Spouse's PIN: check one box only
☐ I authorize ____ to enter or generate my PIN
as my signature on my tax year 2017 electronically filed income tax return.
☐ I will enter my PIN as my signature on my tax year 2017 electronically filed income tax return. Check this box only if you are entering your own PIN and your return is filed using a Practitioner PIN method. The ERO must complete Part III below.
Spouse's signature ▶ Date ▶

Practitioner PIN Method Returns Only — continue below

Part III Certification and Authentication — Practitioner PIN Method Only

ERO's EFIN/PIN. Enter your six-digit EFIN followed by your five-digit self-select PIN

I certify that the above numeric entry is my PIN, which is my signature for the tax year 2017 electronically filed return for the taxpayer(s) indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 1345, Handbook for Authorized IRS e-file Providers of Individual Income Tax Returns.

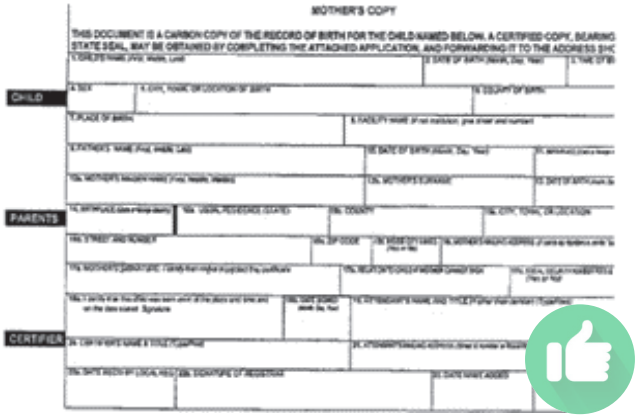
ERO's signature ▶ Date ▶

ERO Must Retain This Form — See Instructions
Don't Submit This Form to the IRS Unless Requested To Do So

For Paperwork Reduction Act Notice, see your tax return instructions.

CERTIFICATE OF BIRTH

MOTHERS COPY


MOTHER'S COPY

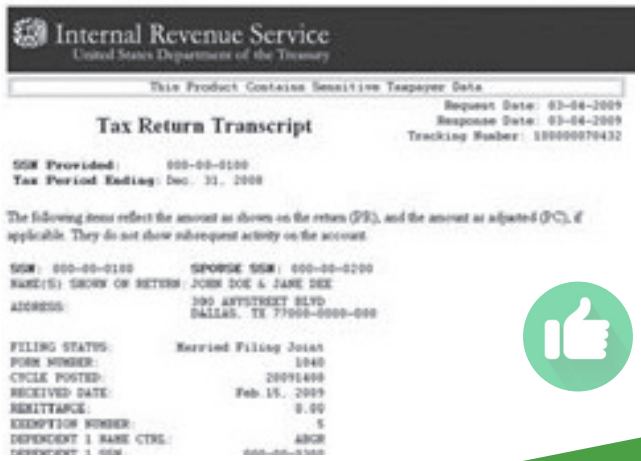
THIS DOCUMENT IS A CARBON COPY OF THE RECORD OF BIRTH FOR THE CHILD NAMED BELOW. A CERTIFIED COPY, BEARING STATE SEAL, MAY BE OBTAINED BY COMPLETING THE ATTACHED APPLICATION AND FORWARDING IT TO THE ADDRESS SHO

CHILD

PARENTS

CERTIFIER

TAX TRANSCRIPT


Internal Revenue Service
United States Department of the Treasury

This Product Contains Sensitive Taxpayer Data

Tax Return Transcript

Request Date: 03-06-2009
Response Date: 03-06-2009
Tracking Number: 100000070432

SSN Provided: 000-00-0100
Tax Period Ending: Dec. 31, 2008

The following items reflect the amount as shown on the return (PY), and the amount as adjusted (PC), if applicable. They do not show subsequent activity on the account.

SSN: 000-00-0100 SPOUSE SSN: 000-00-0200
NAME(S) SHOWN ON RETURN: JOHN DOE & JANE DEE
ADDRESS: 300 ANYSTREET BLVD
DALLAS, TX 77000-0000-000

FILING STATUS:	Married Filing Joint
FORM NUMBER:	1040
CYCLE POSTED:	20091400
RECEIVED DATE:	Feb 15, 2009
REMITTANCE:	0.00
EXEMPTION NUMBER:	5
DEPENDENT 1 NAME CTRL:	ABCR

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

ACCEPTABLE DOCUMENTATION FOR DEPENDENTS:

VERIFICATION OF FACTS FOR DEPENDENTS UNDER 6 MONTHS OF AGE

Verification of Facts

PARENT 1 : BIRTHING MOTHER'S INFORMATION

PARENT 2 : FATHER/PARENT INFORMATION

I certify that I have reviewed the above information and attest that the information is correct.

AFFIDAVIT OUT OF WEDLOCK

AFFIDAVIT OF PARENTAGE FOR CHILD BORN OUT OF WEDLOCK

INFORMATION CONCERNING THE FATHER

CERTIFICATION OF PARENTS

CERTIFICATE OF MARRIAGE

Certificate of Marriage

This certifies that

&

Were United in The Holy Bonds Of Matrimony

At

On the Day of in the year

Signatures &

Witnessed &

Officiated by

Authorized By Signature

DIVORCE DECREE

NO. _____

IN THE MATTER OF THE MARRIAGE OF	§	IN THE DISTRICT COURT
JANE DOE AND JOHN DOE	§	___ JUDICIAL DISTRICT
	§	BELL COUNTY, TEXAS

FINAL DECREE OF DIVORCE

On _____ the Court heard this case.

Appearances

Petitioner, JANE DOE, appeared in person and announced ready for trial.

Respondent, JOHN DOE,

☐ appeared in person and announced ready.

☐ although duly and properly cited to appear or answer failed to appear or answer and wholly made default.

☐ has made a general appearance and was duly notified of trial but failed to appear and wholly made default.

☐ waived issuance and service of citation by waiver duly filed and did not otherwise appear.

Record

The making of a record of testimony was waived by the parties with the consent of the Court.

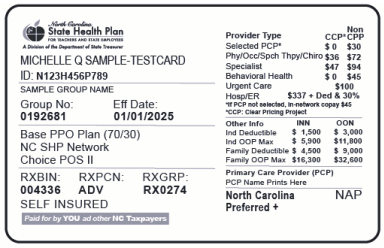
OR

A record of testimony was duly reported by the Court's reporter.

Jurisdiction and Domicile

EXAMPLE

INSURANCE CARD WITH EFFECTIVE DATE



State Health Plan

MICHELLE Q SAMPLE-TESTCARD

ID: N123H456P789

SAMPLE GROUP NAME

Group No: 0192681 Eff Date: 01/01/2025

Base PPO Plan (70/30)
NC SHP Network
Choice POS II

RXBIN: 004336 RXPCN: ADV RXGRP: RX0274

SELF INSURED

Paid for by YOU and other NC Taxpayers

Provider Type	CCP*	Non CCP
Selected PCP*	$ 0	$30
Phy/Occ/Spch Thpy/Chiro	$36	$72
Specialist	$47	$94
Behavioral Health	$ 0	$45
Urgent Care	$100	
Hosp/ER	$337 + Ded & 30%	

*If PCP not selected, in-network copay $45
*CCP: Clear Pricing Project

Other Info	INN	OON
Ind Deductible	$ 1,500	$ 3,000
Ind OOP Max	$ 5,900	$11,800
Family Deductible	$ 4,500	$ 9,000
Family OOP Max	$16,300	$32,600

Primary Care Provider (PCP)
PCP Name Prints Here

North Carolina Preferred + NAP

Third Party Administrator: aetna

Pharmacy Benefits Administrator: CVS caremark

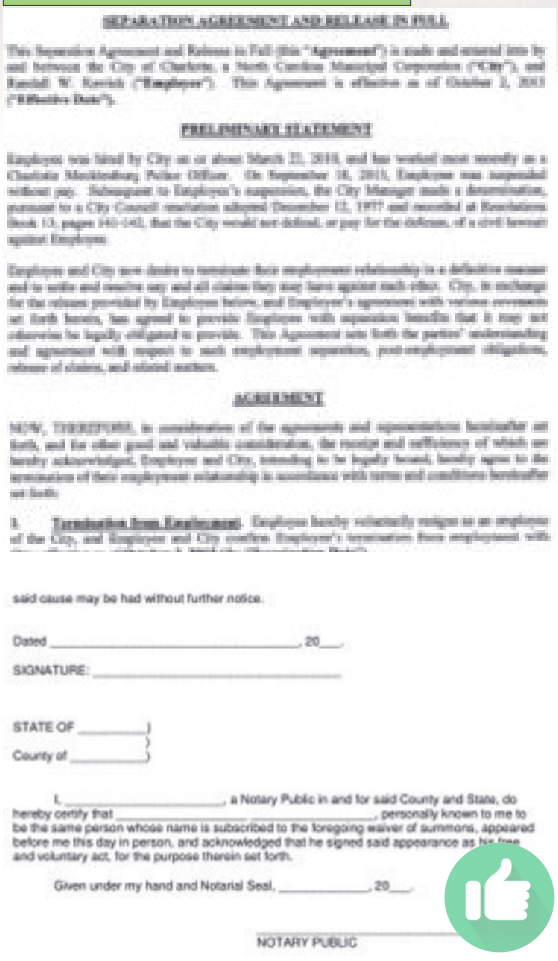
Benefits & Claims Number	1-833-690-1037
Eligibility & Enrollment	1-855-859-0966
Behavioral Health	1-800-424-4047
Provider Relations/Precert	1-888-632-3862
Pharmacy Help Desk	1-800-364-6331
CVS Caremark	1-888-321-3124
Aetna Life Insurance Company	PAYER NUMBER 60
Submit Claims To:	Talk to a doctor 24
PO Box 14079	1-855-TELADOC
Lexington, KY 40512-4079	www.SHPNC.org

Aetna provides administrative services only for the self funded plan, and assumes no financial risk or obligations with respect to claims. Claims may be subject to review. Members are responsible for obtaining the prior authorization for certain services and/or outpatient services for non-participating providers.

State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

ACCEPTABLE DOCUMENTATION FOR DEPENDENTS:

LEGAL SEPARATION WITH NOTARY



SEPARATION AGREEMENT AND RELEASE IN FULL

PRELIMINARY STATEMENT

AGREEMENT

said cause may be had without further notice.

Dated _____, 20___.

SIGNATURE: _____

STATE OF _____)
)
County of _____)

I, _____, a Notary Public in and for said County and State, do hereby certify that _____, personally known to me to be the same person whose name is subscribed to the foregoing waiver of summons, appeared before me this day in person, and acknowledged that he signed said appearance as his free and voluntary act, for the purpose therein set forth.

Given under my hand and Notarial Seal, _____, 20___.

NOTARY PUBLIC

MONTHLY UTILITY BILL

DUKE ENERGY. PROGRESS

Customer Bill

Account number

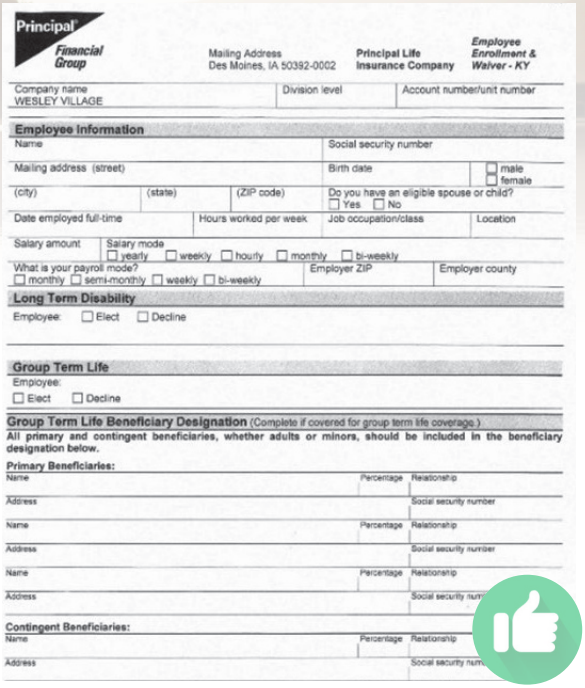
Total due

Current charges past due after

Employee and Spouse's Name and Address

Usage

BENEFICIARY DESGINATION



Principal Financial Group

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - KY

Company name
WESLEY VILLAGE

Division level

Account number/unit number

Employee Information

Name

Social security number

Mailing address (street)

Birth date

☐ male ☐ female

(city) (state) (ZIP code)

Do you have an eligible spouse or child? ☐ Yes ☐ No

Date employed full-time

Hours worked per week

Job occupation/class

Location

Salary amount

Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly

What is your payroll mode? ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly

Employer ZIP

Employer county

Long Term Disability

Employee: ☐ Elect ☐ Decline

Group Term Life

Employee: ☐ Elect ☐ Decline

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name Percentage Relationship

Address Social security number

Contingent Beneficiaries:

Name Percentage Relationship

Address Social security number

PROPERTY / VEHICLE TAX

NC COMBINED VEHICLE REGISTRATION RENEWAL AND PROPERTY TAX NOTICE

Date of Notice:

Customer:

VEHICLE PROPERTY TAX INFORMATION

Tax County:

Appraised Value:

Taxing Districts

Tax Rate Per $100 Value

Amount Due

Property Tax Questions/Appeals:

PROPERTY TAX: $

Vehicle Registration Questions:

NC Division of Motor Vehicles

919-814-1779

www.ncdot.gov/dmv/

"ATTENTION"

VEHICLE REGISTRATION / INSPECTION INFORMATION

Year:

License#:

Make:

Due Date:

Style:

VIN:

Licensed Weight:

Title Number:

Equip #:

Classification:

Lessor Name:

Insurance Co:

Policy Number:

REGISTRATION FEE: $

TOTAL AMOUNT DUE: $

Due Date

PLEASE DETACH & RETURN THIS PORTION WITH YOUR PAYMENT

Tax County

License # Title Number Vehicle Identification Number Year Make Style Licensed Weight

IF TOTAL AMOUNT IS NOT PAID IN FULL REGISTRATION WILL NOT BE PROCESSED

Total Amount Due

Name and Address

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

ACCEPTABLE DOCUMENTATION FOR DEPENDENTS:

ADOPTION DECREE

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
FAMILY COURT
DOMESTIC RELATIONS BRANCH – ADOPTION

EX PARTE IN THE MATTER OF
THE PETITION OF
[Petitioners' Initials]
FOR ADOPTION OF MINOR CHILD

Adoption Case No. A-_____
JUDGE RONNA LEE BECK

FINAL DECREE OF ADOPTION

Upon consideration of the Petition for Adoption filed by [current name of child]' for the adoption of a minor child born [current name of child], in [current name of child], and upon the report and recommendation of the Child and Family Services Agency of the District of Columbia or other [illegible], it appears to the satisfaction of the court: (1) That the court has jurisdiction pursuant to D.C. Code Ann. § 16-301 (2001); (2) That the adoptee is physically, mentally, and otherwise suitable for adoption by the petitioner; (3) That the petitioner is fit and able to give the adoptee a proper home and education; (4) That the adoption will be for the best int[illegible] of the adoptee; (5) That the adoptee has resided with the petitioner since [o] child] [if this is a foreign readoption, replace with: That the adoptee h[illegible] legal care and control of petitioners by virtue of an adoption [or, if appli[illegible]

QUALIFIED MEDICAL CHILD SUPPORT ORDER

At a term of the Supreme Court of the State of New York, held in and for the County of_____, at _____, New York on _____

PRESENT: Hon._____
Justice/Referee

Plaintiff,
-against-
Defendant.

Index No.:_____

QUALIFIED MEDICAL CHILD SUPPORT ORDER

NOTICE: YOUR WILLFUL FAILURE TO OBEY THIS ORDER MAY, AFTER A COURT HEARING, RESULT IN YOUR COMMITMENT TO JAIL FOR A TERM NOT TO EXCEED SIX MONTHS, FOR CONTEMPT OF COURT.

Pursuant to DRL §240(1). This Qualified Medical Child Support Order (QMCSO) orders and directs that the unemancipated dependents named herein:
Name: Date of Birth: Soc. Sec.#: Mailing Address:

are entitled to be enrolled in and receive the benefits for which the legally responsible relative named herein is eligible, under the group health plan named herein in accordance with Section 609 of the Federal Employee Retirement Income Security Act.

The Participant (legally responsible relative) is:
Name: Soc. Sec.#: Mailing Address:

The Dependents' Custodial Parent or Legal Guardian who is to be provided with [illegible] cards and benefit claim forms on behalf of dependents:
Name: Soc. Sec.#:

The group health plan subject to this order is:

COURT APPOINTED GUARDIAN

STATE OF NORTH CAROLINA
_____ County
IN THE MATTER OF THE ESTATE OF:

In The General Court Of Justice
Superior Court Division
Before the Clerk

LETTERS OF APPOINTMENT
LIMITED GUARDIAN OF THE PERSON

The Court in the exercise of its jurisdiction for the appointment of guardians of incompetent persons, and upon proper application, has appointed the person(s) named below as Limited Guardian(s) of the Person of the ward named above and has ordered that these Letters of Appointment be issued.

Except as set forth below, the Limited Guardian of the Person is fully authorized and entitled under the laws of North Carolina to have custody, care and control of the ward.

The ward retains the following legal rights and privileges:
(Check all that apply)

☐ Determine his/her degree of participation in interpersonal relationships and social, religious, and community activities.
Additional Specification: _____
☐ Make ☐ Assist in decisions regarding living arrangements.
Additional Specification: _____
☐ Make ☐ Assist in decisions regarding employment.
Additional Specification: _____
☐ Make ☐ Assist in decisions regarding health treatment.
Additional Specification: _____
☐ Take care of minor health problems.
Additional Specification: _____
☐ Contract services providers as needed.
Additional Specification: _____
☐ Make decisions regarding social, religious, and community activities.
Additional Specification: _____
☐ Other: _____

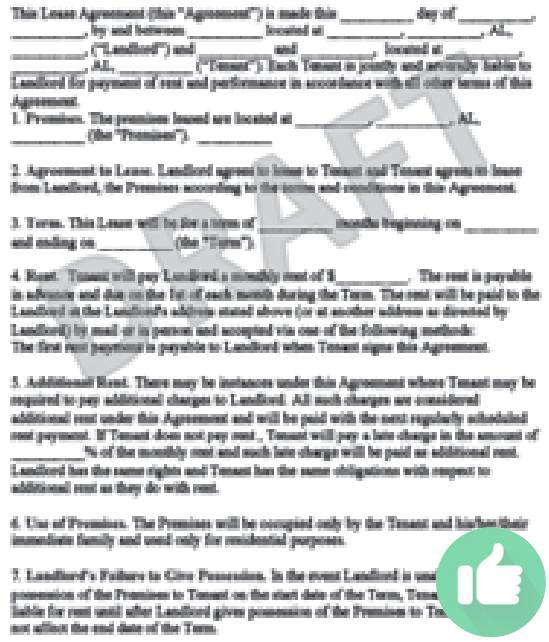
These Letters are issued to attest to that authority and to certify that it is now in full force and effect.

Witness my hand and the Seal of the Superior Court.

EX OFFICIO JUDGE OF PROBATE

NOTE: [illegible] official seal of the Clerk of Superior Court.

LEASE AGREEMENT



This Lease Agreement (this "Agreement") is made this _____ day of _____, _____, by and between _____ located at _____, _____, AL, _____, ("Landlord") and _____ and _____, located at _____, _____, AL, _____ ("Tenant"). Each Tenant is jointly and severally liable to Landlord for payment of rent and performance in accordance with all other terms of this Agreement.

1. Premises. The premises leased are located at _____, _____, AL, _____ (the "Premises").

2. Agreement to Lease. Landlord agrees to lease to Tenant and Tenant agrees to lease from Landlord, the Premises according to the terms and conditions in this Agreement.

3. Term. This Lease will be for a term of _____ months beginning on _____ and ending on _____ (the "Term").

4. Rent. Tenant will pay Landlord a monthly rent of $_____. The rent is payable in advance and due on the 1st of each month during the Term. The rent will be paid to the Landlord at the Landlord's address stated above (or at another address as directed by Landlord) by mail or in person and accepted via one of the following methods:
The first rent payment is payable to Landlord when Tenant signs this Agreement.

5. Additional Rent. There may be instances under this Agreement where Tenant may be required to pay additional charges to Landlord. All such charges are considered additional rent under this Agreement and will be paid with the next regularly scheduled rent payment. If Tenant does not pay rent., Tenant will pay a late charge in the amount of _____% of the monthly rent and such late charge will be paid as additional rent. Landlord has the same rights and Tenant has the same obligations with respect to additional rent as they do with rent.

6. Use of Premises. The Premises will be occupied only by the Tenant and his/her/their immediate family and used only for residential purposes.

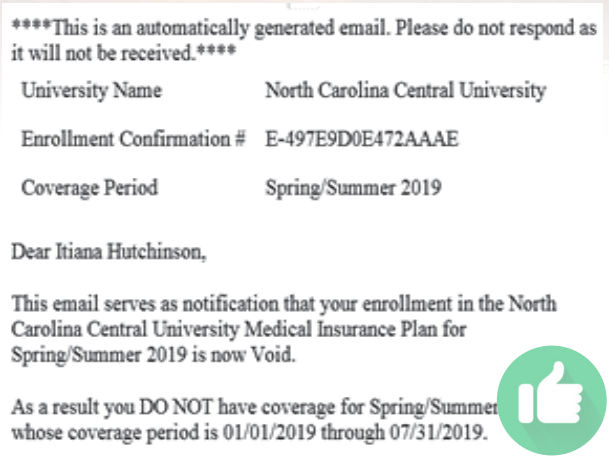
7. Landlord's Failure to Give Possession. In the event Landlord is una[illegible] possession of the Premises to Tenant on the start date of the Term, Tena[illegible] liable for rent until after Landlord gives possession of the Premises to Te[illegible] not affect the end date of the Term.

DRAFT

State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility

ACCEPTABLE DOCUMENTATION FOR DEPENDENTS:

LOSS OF OTHER COVERAGE LETTER



****This is an automatically generated email. Please do not respond as it will not be received.****

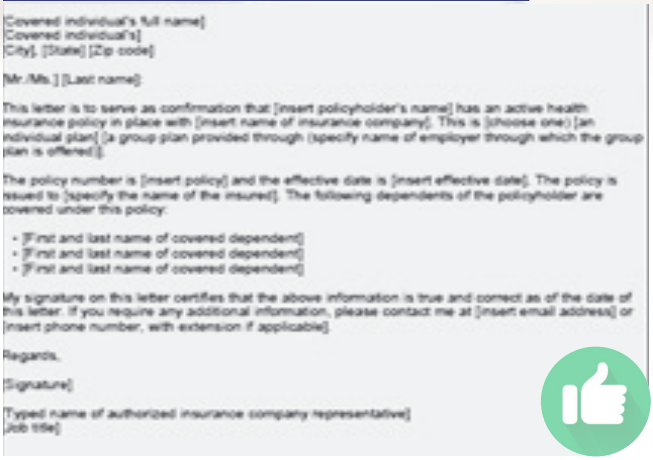
University Name	North Carolina Central University
Enrollment Confirmation #	E-497E9D0E472AAAE
Coverage Period	Spring/Summer 2019

Dear Itiana Hutchinson,

This email serves as notification that your enrollment in the North Carolina Central University Medical Insurance Plan for Spring/Summer 2019 is now Void.

As a result you DO NOT have coverage for Spring/Summer
whose coverage period is 01/01/2019 through 07/31/2019.

NOW ELIGIBLE FOR OTHER COVERAGE LETTER



[Covered individual's full name]
[Covered individual's]
[City], [State] [Zip code]

Mr./Ms.] [Last name]:

This letter is to serve as confirmation that [insert policyholder's name] has an active health insurance policy in place with [insert name of insurance company]. This is [choose one:] [an individual plan] [a group plan provided through (specify name of employer through which the group plan is offered)].

The policy number is [insert policy] and the effective date is [insert effective date]. The policy is issued to [specify the name of the insured]. The following dependents of the policyholder are covered under this policy:

- [First and last name of covered dependent]
- [First and last name of covered dependent]
- [First and last name of covered dependent]

My signature on this letter certifies that the above information is true and correct as of the date of this letter. If you require any additional information, please contact me at [insert email address] or [insert phone number, with extension if applicable].

Regards,

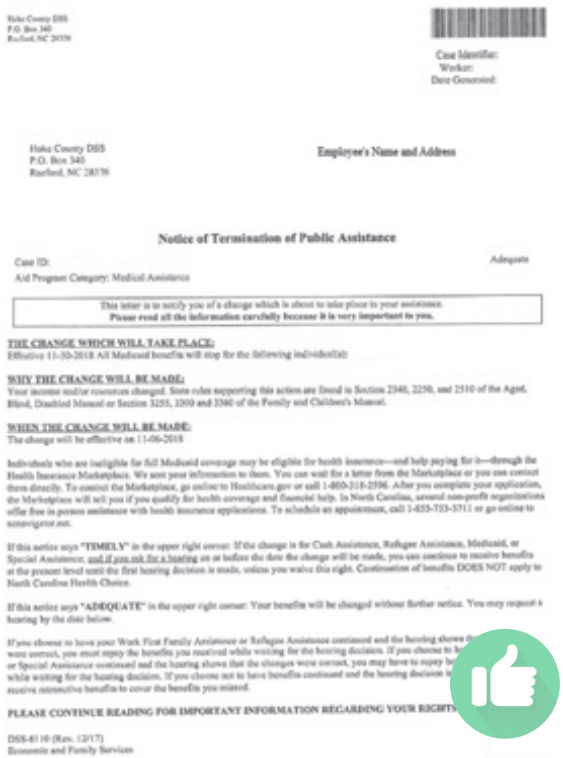
[Signature]

[Typed name of authorized insurance company representative]
[Job title]

MEDICAID APPROVAL LETTER

PLEASE READ THIS IMPORTANT NOTICE ABOUT YOUR MEDICAID OR SPECIAL ASSISTANCE
APPROVAL NOTICE

MEDICAID TERMINATION LETTER



Employer's Name and Address

Notice of Termination of Public Assistance

THE CHANGE WHICH WILL TAKE PLACE:

WHY THE CHANGE WILL BE MADE:

WHEN THE CHANGE WILL BE MADE:

PLEASE CONTINUE READING FOR IMPORTANT INFORMATION REGARDING YOUR RIGHTS

Please note:
Review your benefit booklet for further details.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer