

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 are required to provide supporting documentation. Documentation must be uploaded in the Document Center of eBenefits, the Plan's enrollment system 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 <i>(may only be used to add dependents; cannot be used to drop dependents)</i>	
CHANGE in COUNTRY OF RESIDENCE	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.
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 GROUP 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. <i>Note: Losing individual or marketplace 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.</i>
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.

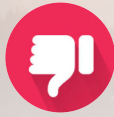
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DEPENDENT ELIGIBILITY	REQUIRED DOCUMENTATION FROM EMPLOYEE
<p>LEGAL MARRIED SPOUSE <i>Defined as legally married spouse, includes same and opposite gender spouses.</i></p>	<p>Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A, 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 </p>
<p>BIOLOGICAL CHILD UNDER the AGE of 26 <i>Defined as your biological child, includes child of same gender spouse.</i></p>	<p>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 <ul style="list-style-type: none"> • Birth Certificate or Mother's Copy with subscriber's name listed as parent • Verification of Facts within 6 months of birth </p>
<p>STEPCHILD UNDER the AGE of 26 <i>Defined as your stepchild.</i></p>	<p>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 <ul style="list-style-type: none"> • 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 </p>
<p>ADOPTED CHILD UNDER the AGE of 26 <i>Defined as a child you have legally adopted, or has been placed with you for adoption or in anticipation of legal adoption.</i></p>	<p>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 <ul style="list-style-type: none"> • International adoption papers from the country of adoption • Official adoption agreement from adoption agency showing intent to adopt the dependent </p>
<p>FOSTER CHILD UNDER the AGE of 26 <i>Defined as your foster child or child placed with you for foster care.</i></p>	<p>Official State Agreement for placement specific to the dependent being added</p>
<p>CHILD UNDER the AGE of 26 for whom the Subscriber is COURT-APPOINTED GUARDIAN <i>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.</i></p>	<p>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</p>
<p>CHILD UNDER the AGE of 26 for whom the Plan has received a QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) <i>Defined as any recognized child you are required to cover under the Plan due to a QMCSO.</i></p>	<p>Court documents signed by a judge Medical support orders issued by a State</p>

*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

TAX FORM SIGNATURE PAGE

CERTIFICATE OF BIRTH

MOTHERS COPY

TAX TRANSCRIPT

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

North Carolina Department of Health and Human Services
N.C. Vital Records

Verification of Facts

PARENT 1 : BIRTHING MOTHER'S INFORMATION

1. Baby's Legal Name	2. Request for Social Security Number
3. Current Legal Name (First, Middle, Last)	4. Marital Status
5. What was your name at birth if different from current legal name?	
6. Date of Birth	7. Place of Birth
8. Residence Address	
9. Mailing City/County?	10. Mailing Address/Residence Address Same?
11. Mailing Address	
12. Social Security Number	13. Education
14. Race	15. Hispanic Origin?
16. Received WIC?	17. Height
18. Cigarettes Smoked	19. Pre-Pregnancy Weight
20.	21.

PARENT 2 : FATHER/PARENT INFORMATION

1. Current Legal Name (First, Middle, Last)	
2. Date of Birth	3. Place of Birth
4. Social Security Number	5. Education
6. Hispanic Origin?	7. Race
8.	9.

Name of Person Providing Information if other than Birthing Mother (First, Middle, Last):
Relationship to Birthing Mother:

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



AFFIDAVIT OUT OF WEDLOCK

North Carolina Department of Health and Human Services
N.C. Vital Records

AFFIDAVIT OF PARENTAGE FOR CHILD BORN OUT OF WEDLOCK

My female partner and I have had a child together. I am the biological father of the child named above. I declare and affirm that I am the biological father of the child named above. I declare and affirm that I am the biological father of the child named above. I declare and affirm that I am the biological father of the child named above.

INFORMATION CONCERNING THE FATHER

Is father of Hispanic origin? Yes No
If yes, specify Cuban, Mexican, Puerto Rican, etc.

CERTIFICATION OF PARENTS

I acknowledge that I have reviewed and understood the information on the other side of this form that explains the purpose and consequences of signing this document, including possible requirements in my child's region.

Mother
I am the natural mother and the man named above is the natural father of the child named above. I declare and affirm that I am the biological mother of the child named above. I declare and affirm that I am the biological mother of the child named above. I declare and affirm that I am the biological mother of the child named above.

Father
I acknowledge that I am the natural father of the child named above. I understand that this affidavit shall remain signed and correct for both parents. From the time this affidavit is filed as a judgment of the court in accordance with the provisions of the above-mentioned child.

Signature of Mother: _____
Signature of Father: _____

Notary Public: _____
Notary Public: _____



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 JANE DOE AND JOHN DOE

IN THE DISTRICT COURT _____ 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



INSURANCE CARD WITH EFFECTIVE DATE

<p>State Health Plan A member of the Department of Health Services</p> <p>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 ADV RXGRP: RXGRP: RX0274 SELF INSURED</p> <p>Provider Type Selected PCP* \$ 0 \$ 50 Phy/Occ/Sph Thpy/Chro \$36 \$72 Specialist \$47 \$94 Behavioral Health \$ 0 \$45 Urgent Care \$100 Hospital* \$337 + Dnd & 30% *PCP not selected, in-network copy \$45 *CCP Case Pricing Project</p> <p>Other Info INN OON Ind Deductible \$ 1,500 \$ 3,000 Ind OOP Max \$ 5,000 \$11,000 Family Deductible \$ 4,500 \$ 9,000 Family OOP Max \$15,000 \$31,000 Primary Care Provider (PCP) PCP Name Prints Here</p> <p>North Carolina Preferred +</p> <p>Non CCP/CCP \$ 0 \$ 50 Specialist \$47 \$94 Behavioral Health \$ 0 \$45 Urgent Care \$100 Hospital* \$337 + Dnd & 30% *PCP not selected, in-network copy \$45 *CCP Case Pricing Project</p> <p>INN OON Ind Deductible \$ 1,500 \$ 3,000 Ind OOP Max \$ 5,000 \$11,000 Family Deductible \$ 4,500 \$ 9,000 Family OOP Max \$15,000 \$31,000 Primary Care Provider (PCP) PCP Name Prints Here</p> <p>North Carolina Preferred +</p> <p>Paid for by YOU or other HC Taxpayers</p>	<p>Third Party Administrator: aetna Pharmacy Benefits Administrator: CVS caremark</p> <p>Benefits & Claims Number 1-833-690-1037 Eligibility & Enrollment 1-855-859-0966 Behavioral Health 1-800-424-4047 Provider Relations/Precert 1-888-632-3662 Pharmacy Help Desk 1-800-364-8311 CVS Caremark 1-888-321-2124</p> <p>Aetna Life Insurance Company PAYER NUMBER 66 Submit Claims To: Talk to a doctor 24 PO Box 14079 1-855-TELADOC Lexington, KY 40512-4079 www.SHNPC.org</p> <p>Aetna provides administrative services only for the self-funded plan, and assumes no financial risk for the plan. Claims may be subject to review. Members are responsible for obtaining the proper and/or out-of-network services for non-participating providers.</p>
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State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility



ACCEPTABLE DOCUMENTATION FOR DEPENDENTS:

LEGAL SEPARATION WITH NOTARY

NOTARIAL AGREEMENT AND RELEASE IN FULL

This Separation Agreement and Release in Full (the "Agreement") is made and entered into by and between the City of Charlotte, a North Carolina Municipal Corporation ("City"), and Randall W. Kernis ("Employee"). This Agreement is effective as of October 1, 2013 ("Effective Date").

PRELIMINARY STATEMENT

Employee was hired by City on or about March 21, 2010, and has worked most recently as a Charlotte-Mecklenburg Police Officer. On September 18, 2011, Employee was suspended without pay. Subsequent to Employee's suspension, the City Manager made a determination, pursuant to a City Council resolution adopted December 13, 2011 and recorded at Resolution Book 13, pages 140-142, that the City would not defend, or pay for the defense, of a civil lawsuit against Employee.

Employee and City are desirous to terminate their employment relationship in a definitive manner and to settle and resolve any and all claims they may have against each other. City, in reliance on the release provided by Employee below, and Employee's agreement with various provisions set forth herein, has agreed to provide Employee with separation benefits that it may not otherwise be legally obligated to provide. This Agreement sets forth the parties' understanding and agreement with respect to such employment separation, post-employment obligations, release of claims, and related matters.

AGREEMENT

NOW, THEREFORE, in consideration of the agreements and representations hereinafter set forth, and the other good and valuable considerations, the receipt and sufficiency of which are hereby acknowledged, Employee and City, intending to be legally bound, hereby agree to the provisions of their employment relationship in accordance with terms and conditions hereinafter set forth:

1. Termination from Employment. Employee hereby voluntarily resigns as an employee of the City, and Employee and City confirm Employee's resignation from employment with

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

Employee and Spouse's Name and Address

Customer Bill page 1 of 1

Account number _____
Total due _____
Current charges past due after _____
Look you for your payment _____
Usage period _____
This bill was mailed on _____

Usage Water number _____
Postings _____
MWh usage _____
Days in period: 30 Average MWh usage _____

Billing Breakdown Service rate

1,100
1,000
900
800
700
600
500
400
300
200
100
0

Jul Sep Nov Jan Mar May Jul

MWh Usage History

00003563177553081014051YNS214303013

Name and Address



BENEFICIARY DESIGNATION

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: _____
Name: _____ Percentage: _____ Relationship: _____
Address: _____ Social security number: _____
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/Answers:
Jackson County Finance Dept
826-613-2299
401 Grandstaff Civic Rd
Salix, NC 28779
www.jackson.org

Please review the Taxing Districts shown on this notice. If the Taxing Districts shown are different than the actual location of this vehicle at the time of appraisal, do not send this coupon by mail because the property tax amount must be re-calculated. If you need a re-calculation see the reverse side for additional information.

PROPERTY TAX: \$ _____

Vehicle Registration Questions:
NC Division of Motor Vehicles
919-814-1779
www.ncdot.gov/dmv/

ATTENTION
A vehicle that is subject to a safety or emissions inspection must have passed an inspection no more than 90 days before the plate expires.
Verify all vehicle information. If incorrect, please make any correction in the space provided on the back of the tear off coupon below.

VEHICLE REGISTRATION / INSPECTION INFORMATION

Year: _____ License #: _____
Make: _____ Due Date: _____
Style: _____ NC INSPECTION REQUIRED
VIN: _____ Licensed Weight: _____
Title Number: _____ Equip #: _____
Lessor Name: _____
Insurance Co: _____ Policy Number: _____

REGISTRATION FEE: \$ _____

TOTAL AMOUNT DUE: \$ _____

Due Date: _____ PLEASE DETACH & RETURN THIS PORTION WITH YOUR PAYMENT Tax County: _____

Classification: PRIVATE PASSENGER VEHICLE

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

00003563177553081014051YNS214303013

Name and Address

00003563177553081014051YNS214303013



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: Adoption Case No. A-_____

THE PETITION OF [Petitioners' Initials]

FOR ADOPTION OF MINOR CHILD

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 reported recommendation of the Child and Family Services Agency of the District of Columbia [or other appropriate agency], 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 interests of the adoptee; (5) That the adoptee has resided with the petitioner since [date of child] [if this is a foreign readoption, replace with: That the adoptee has been in the legal care and control of petitioner by virtue of an adoption [or, if applicable, by a court order of the State of _____] since [date].



COURT APPOINTED GUARDIAN

STATE OF NORTH CAROLINA

In the General Court of Justice
Superior Court Division
Before the Clerk

IN THE MATTER OF THE ESTATE OF _____

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 further degree of participation in interpersonal relationships and social, religious, and community activities.
Additional Specification: _____

Make Assent in decisions regarding living arrangements.
Additional Specification: _____

Make Assent in decisions regarding employment.
Additional Specification: _____

Make Assent in decisions regarding health treatment.
Additional Specification: _____

Take care of minor health problems.
Additional Specification: _____

Contact service providers as needed.
Additional Specification: _____

Make decisions regarding social, religious, and community activities.
Additional Specification: _____

Other: _____

These Letters are issued in strict obedience 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



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 _____, New York, on _____, 20__.

PRESENT: Hon. _____ Justice/Judge

Plaintiff, _____ Index No. _____

Defendant, _____

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 UP TO SIX MONTHS, FOR CONTEMPT OF COURT.

Pursuant to DRG §240(1), This Qualified Medical Child Support Order (QMCSO) orders and directs that the unemancipated dependent(s) 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 409 of the Federal Employee Retirement Income Security Act.

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

The Dependent's Custodial Parent or Legal Guardian who is to be provided with medical insurance cards and benefits claim forms on behalf of dependent(s): Name: _____ Soc. Sec.#: _____

The group health plan subject to this order is: _____



LEASE AGREEMENT

This Lease Agreement (this "Agreement") is made this _____ day of _____, 20____, 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 immediate family and used only for residential purposes.

7. Landlord's Failure to Give Possession. In the event Landlord is unable to give possession of the Premises to Tenant on the start date of the Term, Tenant will be liable for rent until after Landlord gives possession of the Premises to Tenant, not after the end date of the Term.



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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
 NORTH CAROLINA, 20188
 Health Department of Social Services
 (See Mailbox)
APPROVAL
 The application for Medicaid is approved for _____ as _____
 Medicaid Identification Number (MID) is _____
 Eligibility for _____ as _____
 Your patient monthly liability for long term care is _____
 Your Special Assistance/AMB-Care Home Payment is _____
 Your Special Assistance/In-home Payment is _____
 Month: _____ Amount: _____
 Month: _____ Amount: _____
 Month: _____ Amount: _____
 Your Medicaid is approved starting _____ and ending _____
 Medicaid covers all necessary medical services. If you get Medicaid from the Social Security Administration, Medicaid will pay your Medicaid A and B services, deductibles, and co-insurance beginning _____.
 Medicaid pays only Medicaid Part A and B premiums and Medicaid cost sharing for Medicaid and Medicaid-covered services.
 Medicaid pays only your Medicaid Part B premiums.
 Medicaid pays for limited services related to family planning. (See page 2 for limited services)
 Alternative Medicaid coverage is approved for the period(s) of _____
 If you receive Medicaid, Medicaid is responsible for your prescription _____ which says that _____
 Agreement assistance opt-out eligibility factors have been verified and eligibility is established.
DETAILS
 Medicaid Special Assistance/AMB-Care Home Special Assistance/In-home
 is divided from _____ to _____
 The State rules used to make this decision are _____ which says that _____
 Individuals who are ineligible for full Medicaid coverage may be eligible for health insurance—and help paying for it—through the Health Insurance Marketplace. We use your information to help you decide if you are eligible for the Marketplace or you can contact them directly. To contact the Marketplace, go online to Healthcare.gov or call 1-800-318-2796. After you complete your application, the Marketplace will tell you if you qualify for health coverage and financial help. In North Carolina, several non-profit organizations offer free in-person assistance with health insurance applications. To schedule an appointment, call 1-877-724-2796 or go online to marketplace.gov.
HEARING RIGHTS: If you disagree with this decision, you have a right to a hearing to review the decision. Call your caseworker at the number below within 60 days to ask for a hearing. The "60 day" rule starts on the date of the decision. If you do not ask for a hearing by this date, you cannot have a hearing unless you have a good reason for missing the deadline. You may request for benefits at any time. To protect your rights, you may (OPTIONALLY) ASK for a hearing. FREE LEGAL HELP: Free Legal Aid may be available to you. Contact your nearest Legal Aid or Legal Services office, or call 1-877-686-2686 call line.
 Caseworker Name and Phone Number _____
 FOR OFFICE USE ONLY:
 Caseworker ID _____
 Case ID # _____
 Aid Program/Category _____
 WHO WILL RECEIVE A NOTICE WHEN IT IS TIME TO REVIEW YOUR CONTINGENT ELIGIBILITY BENEFIT IS IMPORTANT TO COMPLETE THIS PROCESS TO CONTINUE YOUR HEALTH COVERAGE.
 PLEASE CONTINUE READING FOR IMPORTANT INFORMATION ABOUT YOUR RIGHT TO A HEARING.
 000A-000 02/01/17



MEDICAID TERMINATION LETTER

Hoke County DSS
 P.O. Box 340
 Raeford, NC 28376
 Case Identifier:
 Worker:
 Date Generated:
 Hoke County DSS
 P.O. Box 340
 Raeford, NC 28376
 Employee's Name and Address
Notice of Termination of Public Assistance
 Case ID: _____
 Aid Program Category: Medicaid Assistance
 Adjuvant
 This letter is to notify you of a change which is about to take place in your assistance.
 Please read all the information carefully because it is very important to you.
THE CHANGE WHICH WILL TAKE PLACE:
 Effective 11-30-2018 All Medicaid benefits will stop for the following individual(s): _____
WHY THE CHANGE WILL BE MADE:
 Your income and/or resources changed. State rules regarding this action are found in Section 2340, 2250, and 2310 of the Adult, Blind, Disabled Manual or Section 2255, 2300 and 2390 of the Family and Children's Manual.
WHEN THE CHANGE WILL BE MADE:
 The change will be effective on 11-06-2018
 Individuals who are ineligible for full Medicaid coverage may be eligible for health insurance—and help paying for it—through the Health Insurance Marketplace. We use your information to help you decide if you are eligible for the Marketplace or you can contact them directly. To contact the Marketplace, go online to Healthcare.gov or call 1-800-318-2796. After you complete your application, the Marketplace will tell you if you qualify for health coverage and financial help. In North Carolina, several non-profit organizations offer free in-person assistance with health insurance applications. To schedule an appointment, call 1-877-724-2796 or go online to marketplace.gov.
 If this notice says "TIMELY" in the upper right corner: If the change is for Cash Assistance, Refugee Assistance, Medicaid, or Special Assistance, and if you ask for a hearing on or before the date the change will be made, you can continue to receive benefits at the current level until the first hearing decision is made, unless you waive this right. Continuation of benefits DOES NOT apply to North Carolina Health Choice.
 If this notice says "ADEQUATE" in the upper right corner: Your benefits will be changed without further notice. You may request a hearing by the date below.
 If you choose to have your Work First Family Assistance or Refugee Assistance continued and the hearing shows that you were correct, you must stop the benefits you received while waiting for the hearing decision. If you choose to be on Special Assistance continued and the hearing shows that the changes were correct, you may have to stop the benefits you received while waiting for the hearing decision. If you choose not to have benefits continued and the hearing decision requires retroactive benefits to cover the benefits you missed.
PLEASE CONTINUE READING FOR IMPORTANT INFORMATION REGARDING YOUR RIGHTS.
 DSS-0110 (Rev. 12/17)
 Benefits and Family Services



Please note:
 Review your benefit booklet for further details.