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

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

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

Section 125 of the Internal Revenue Code (IRS) provides guidelines for a Qualifying Life Event (QLE) status change. Employees must upload documents into eBenefits or provide supporting documentation to their Health Benefits Representative to verify the QLE in accordance with State Health Plan rules within 30 days of the QLE or 60 days of becoming entitled to or losing eligibility for Medicaid or the Children's Health Insurance Program (CHIP).

Employees are also required to provide documentation of a dependent's eligibility when added to the Plan due to a New Hire event, a QLE, or during Open Enrollment. Please refer to the chart on page 2 for the list of acceptable documents.

Qualifying Life Events	Required Documentation from Employee
Adoption	Refer to chart on page 2.
Birth	Refer to chart on page 2.
Court Order*	Refer to chart on page 2.
Death of a Dependent	Death Certificate / Obituary
Dependent Gains Medicaid Coverage	Written notification showing effective date of Coverage or ID card with an 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 for adding a dependent.
Guardianship or Legal Custody of a Child	Refer to chart on page 2.
Legal Separation	Separation Agreement or affidavit (sworn, notarized statement) from employee 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 for adding 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 for adding a dependent.
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 adding dependents.
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.
Return from Family and Medical Leave (FMLA)	Refer to chart on page 2 for additional requirements for adding a dependent.
Return from Leave of Absence	Refer to chart on page 2 for additional requirements for adding a dependent.
Return from Military Leave	Requires copy of Active Duty documentation that includes date active duty ends. Refer to chart on page 2 below for additional requirements when adding 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. Refer to chart on page 2 for additional requirements for adding a dependent.

*Court Orders may only be used to add dependents and cannot be used to drop dependents.

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

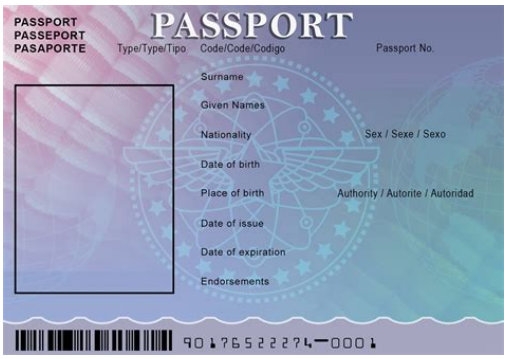
Dependent Verification Requirements	Required Documentation from Employee

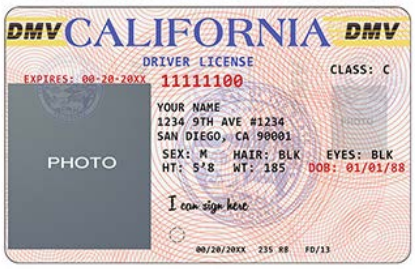
Legal Married Spouse
Defined as legally married spouse and includes same and opposite gender spouses.
	• Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A or 1040EX) as filed with the IRS, listing the spouse (may be joint or separate as long as the spouse is listed) & signed page or official tax transcript
	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 separate of any of the below showing the same address, one listing the employee and the other listing the spouse:
	  • Monthly 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 of the employee's life insurance or retirement benefits and listing primary residence

Biological Child under the age of 26 *Defined as your biological child and Includes child of same gender spouse.*	• Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A or 1040EX) as filed with the IRS**,** listing the child as dependent & signed page or official tax transcript **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 1040EX) as filed with the IRS**,** listing the step child as dependent & signed page or official tax transcript **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 *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 1040EX) as filed with the IRS**,** listing the step child or adopted child as dependent & signed page or official tax transcript **OR** • International adoption papers from country of adoption • Official adoption agreement for the dependent being added from the adoption agency showing intent to adopt
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(s) 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 child's court-ordered guardian or has been awarded legal and physical custody of the child, pursuant to a valid court order.*	• Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A or 1040EX) as filed with the IRS, listing the child as a dependent & signed page or official tax transcript **OR** • Court documents signed by a judge verifying legal custody of the child
Child under age 26 for whom the Plan has received a Qualified Medical Child Support Order (QMCSO) *Defined as any recognized child(ren) you are required to cover under the Plan due to a Qualified Medical Child Support Order (QMCSO).*	• Court documents signed by a judge • Medical support orders issued by a State

*Most recent tax form from the previous year. If not available, the year prior will be accepted along with a letter indicating you have an extension. **Employees that have been married less than a year are able to submit a marriage certificate only.

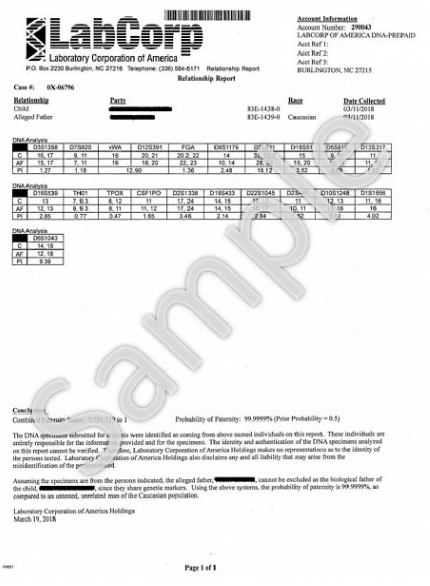
Unacceptable Documentation for Dependents:

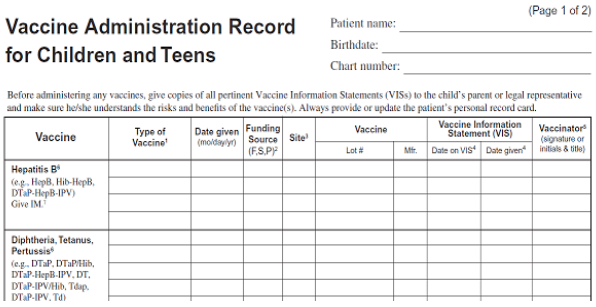




Paternity Results

Birth Certificate Application

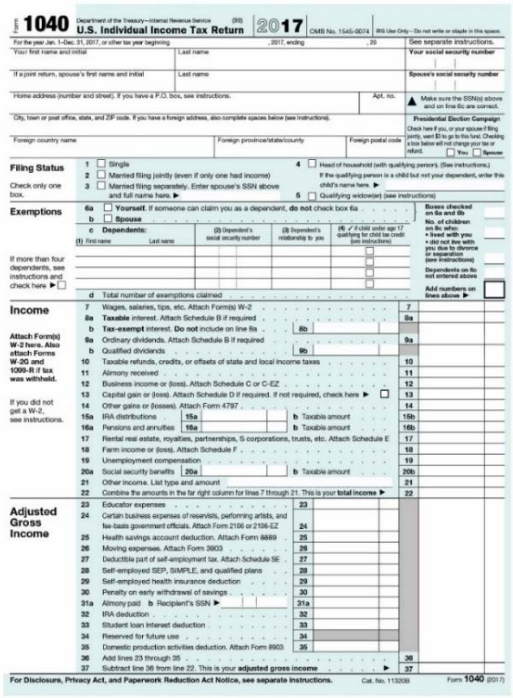




Immunization Records

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

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

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.

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

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.)
5 ☐ Qualifying widow(er) (see instructions)

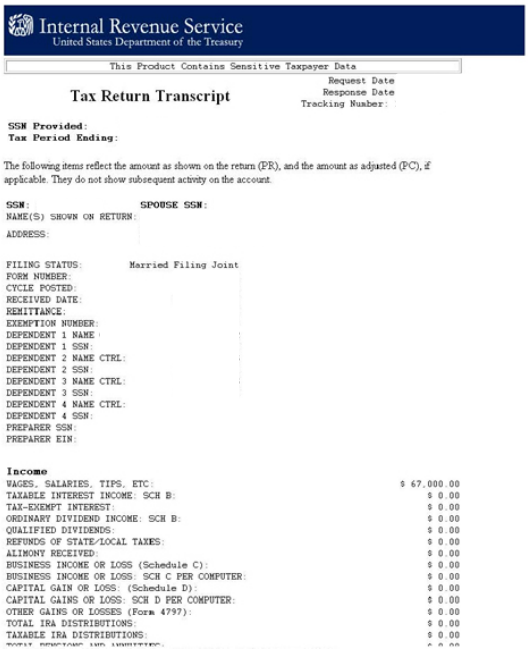
Exemptions
6a ☐ Yourself. If someone can claim you as a dependent, do not check box 6a
b ☐ Spouse
c Dependents: (1) First name Last name | (2) Dependent's social security number | (3) Dependent's relationship to you | (4) ✓ if child under age 17 qualifying for child tax credit (see instructions)
If more than four dependents, see instructions and check here ☐
d Total number of exemptions claimed

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
33 Student loan interest deduction
34 Reserved for future use
35 Domestic production activities deduction. Attach Form 8903
36 Add lines 23 through 35
37 Subtract line 36 from line 22. This is your **adjusted gross income**

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 11320B Form **1040** (2017)

Tax Transcript



Internal Revenue Service
United States Department of the Treasury

This Product Contains Sensitive Taxpayer Data

Tax Return Transcript

Request Date
Response Date
Tracking Number:

SSN Provided:
Tax Period Ending:

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

SSN: SPOUSE SSN:
NAME(S) SHOWN ON RETURN:
ADDRESS:

FILING STATUS: Married Filing Joint
FORM NUMBER:
CYCLE POSTED:
RECEIVED DATE:
REMITTANCE:
EXEMPTION NUMBER:
DEPENDENT 1 NAME:
DEPENDENT 1 SSN:
DEPENDENT 2 NAME CTRL:
DEPENDENT 2 SSN:
DEPENDENT 3 NAME CTRL:
DEPENDENT 3 SSN:
DEPENDENT 4 NAME CTRL:
DEPENDENT 4 SSN:
PREPARER SSN:
PREPARER EIN:

Income

WAGES, SALARIES, TIPS, ETC:	$ 67,000.00
TAXABLE INTEREST INCOME: SCH B:	$ 0.00
TAX-EXEMPT INTEREST:	$ 0.00
ORDINARY DIVIDEND INCOME: SCH B:	$ 0.00
QUALIFIED DIVIDENDS:	$ 0.00
REFUNDS OF STATE/LOCAL TAXES:	$ 0.00
ALIMONY RECEIVED:	$ 0.00
BUSINESS INCOME OR LOSS (Schedule C):	$ 0.00
BUSINESS INCOME OR LOSS: SCH C PER COMPUTER:	$ 0.00
CAPITAL GAIN OR LOSS: (Schedule D):	$ 0.00
CAPITAL GAINS OR LOSS: SCH D PER COMPUTER:	$ 0.00
OTHER GAINS OR LOSSES (Form 4797):	$ 0.00
TOTAL IRA DISTRIBUTIONS:	$ 0.00
TAXABLE IRA DISTRIBUTIONS:	$ 0.00

Tax Form Signature Page

Form **8879** **IRS *e-file* Signature Authorization** OMB No. 1545-0074
Department of the Treasury Internal Revenue Service
► Return completed Form 8879 to your ERO. (Do not send to IRS.)
► Go to www.irs.gov/Form8879 for the latest information.
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 39; Form 1040EZ, line 12; Form 1040NR, line 61)
3 Federal income tax withheld from Forms 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 48a; Form 1040EZ, line 13a; Form 1040-SS, Part I, line 13a; Form 1040NR, line 73a)
5 Amount you owe (Form 1040, line 78; Form 1040A, line 56; Form 1040EZ, line 14; Form 1040NR, line 75)

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

Under penalties of perjury, I declare that I have examined a copy of my electronic individual income tax return and accompanying schedules and statements for the tax year ending December 31, 2017, and to the best of my knowledge and belief, it is true, correct, and complete. I will keep a copy of my return for my records. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send my return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an ACH electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of my federal taxes owed on this return and/or a payment of estimated tax, and the financial institution to debit the entry to this account. This authorization is to remain in full force and effect until I notify the U.S. Treasury Financial Agent to terminate the authorization. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537. A payment cancellation request must be received no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I further acknowledge that the personal identification number (PIN) below is my signature for my electronic income tax return and, if applicable, my Electronic Funds Withdrawal Consent.

Taxpayer's PIN: check one box only
☐ I authorize _____ to enter or generate my PIN (ERO firm name) (Enter five digits, but don't enter all zeros) 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 the 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 (ERO firm name) (Enter five digits, but don't enter all zeros) 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 the 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-selected PIN. (Don't enter all zeros)

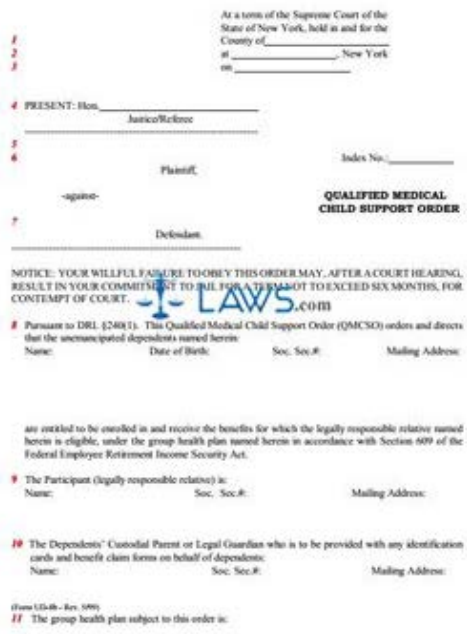
I certify that the above numeric entry is my PIN, which is my signature for the tax year 2017 electronically filed income tax return for the taxpayer(s) indicated above. I confirm that I am submitting this return in accordance with the requirements of the Practitioner PIN method and Pub. 1345, Handbook 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. Form **8879** (2017)

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

Index No. _____

Plaintiff,

-against-

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Defendant.

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 any identification cards and benefit claim forms on behalf of dependents:
Name: Soc. Sec.#: Mailing Address:

(Form UD-8b - Rev. 5/99)
The group health plan subject to this order is:

THE CITY OF NEW YORK
VITAL RECORDS CERTIFICATE

CERTIFICATION OF BIRTH

This is a certification of name and birth facts on file in the Office of Vital Records, Department of Health and Mental Hygiene, City of New York.

DATE OF BIRTH: JANUARY 01, 2000
CERTIFICATE NO.: 15A-00-199999
BOROUGH: MANHATTAN
DATE FILED: 01-03-00
DATE ISSUED: 12-08-11
NAME: CHILDS TEST TESTDATA***
SEX: FEMALE
MOTHER/PARENT'S NAME: MOTHERS TEST TESTDATA
FATHER/PARENT'S NAME: FATHERS TEST TESTDATA

Steven P. Schwartz, Phd
City Registrar

SAMPLE COPY

The City of New York

N00022594

14473783

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

Verification of Facts for Dependents under 6 months of age

Affidavit Out of Wedlock

Iredell Memorial Hospital
Baby's Date of Birth:
Baby's Time of Birth:
Baby's Sex:

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

Verification of Facts

PARENT 1 : BIRTHING MOTHER'S INFORMATION

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

PARENT 2 : FATHER/PARENT INFORMATION

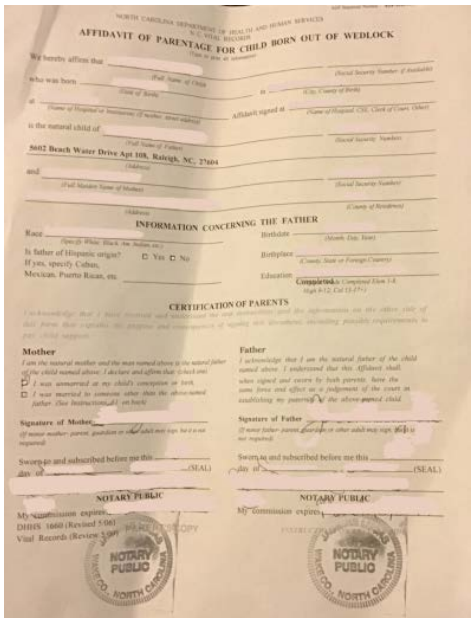
Current Legal Name (First) (Middle) (Last) 19.		
Date of Birth 20.	Place of Birth 21.	
Social Security Number 22.	Education 23.	
Hispanic Origin ? 24.	Race 25.	

Name of Person Providing Information if other than Birthing Mother (First) (Middle) (Last) 26a.
Relationship to Birthing Mother 26b.

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

Mother's Signature _____ Date _____

Revised 1/17



NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
N.C. VITAL RECORDS

AFFIDAVIT OF PARENTAGE FOR CHILD BORN OUT OF WEDLOCK

We hereby affirm that _____ (Social Security Number- if available)
who was born _____ (Full Name of Child) _____ (Date of Birth) in _____ (City, County of Birth)
at _____ (Name of Hospital or Institution if mother delivered there) Affidavit signed at _____ (Name of Hospital, City, Clerk of Court, Other)
is the natural child of _____ (Full Name of Father) _____ (Social Security Number)
8602 Beach Water Drive Apt 108, Raleigh, NC, 27604 (Address)
and _____ (Full Maiden Name of Mother) _____ (Social Security Number)
_____ (Address) _____ (County of Residence)

INFORMATION CONCERNING THE FATHER

Race _____ (Specify White, Black, Am. Indian, etc.) Birthdate _____ (Month, Day, Year)
Is father of Hispanic origin? ☐ Yes ☐ No Birthplace _____ (County, State or Foreign Country)
If yes, specify Cuban, Mexican, Puerto Rican, etc. _____ Education _____ Completed (Check Highest Grade Completed Elem 1-8, High 9-12, Col 13-17+)

CERTIFICATION OF PARENTS

I acknowledge that I have received and understand the oral information and the information on the other side of this form that explains the purpose and consequences of signing and establishes paternity and responsibilities for my child support.

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 (check one)
☐ I was unmarried at my child's conception or birth
☐ I was married to someone other than the above-named father. (See Instructions on back)

Signature of Mother _____
(If minor mother, parent, guardian or other adult may sign, but it is not required)
Sworn to and subscribed before me this _____ day of _____ (SEAL)
_____ NOTARY PUBLIC
My commission expires _____

Father
I acknowledge that I am the natural father of the child named above. I understand that this Affidavit, when signed and sworn by both parents, have the same force and effect as a judgement of the court in establishing my paternity of the above-named child.

Signature of Father _____
(If minor father, parent, guardian or other adult may sign, but it is not required)
Sworn to and subscribed before me this _____ day of _____ (SEAL)
_____ NOTARY PUBLIC
My commission expires _____

DHHS 1660 (Revised 5/06)
Vital Records (Revised 5/06)

NOTARY PUBLIC WAKE CO. NORTH CAROLINA

NOTARY PUBLIC WAKE CO. NORTH CAROLINA

Lease Agreement

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 unable to give possession of the Premises to Tenant on the start date of the Term, Tenant will not be liable for rent until after Landlord gives possession of the Premises to Tenant. This does not affect the end date of the Term.

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

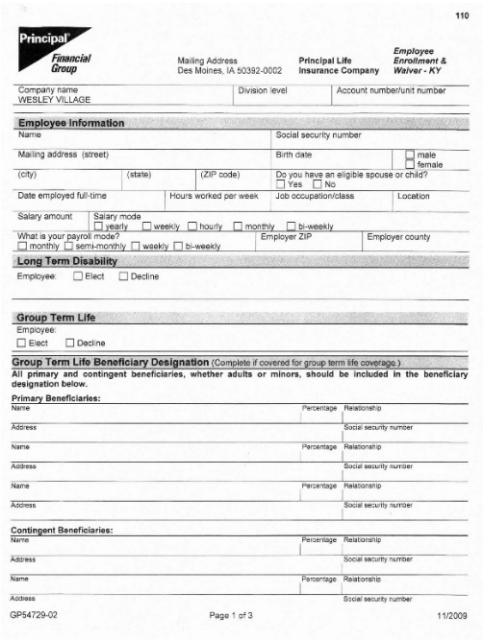
Adoption Case No. A-_____
JUDGE

FINAL DECREE OF ADOPTION

Upon consideration of the Petition for Adoption filed by [current name of child][1] 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 adoption 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 [current name of child] [if this is a foreign readoption, replace with: That the adoptee has been in the legal care and control of petitioners by virtue of an adoption [or, if applicable, a guardianship] in [current name of child] on [current name of child], and has resided with them since that date], which is more than six months preceding the date of this

1 If there are two petitioners, modify the order appropriately throughout.

Beneficiary Designation



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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
Name Percentage Relationship
Address Social security number

GP54729-02 Page 1 of 3 11/2009

Legal Separation w/ Notary

SEPARATION AGREEMENT AND RELEASE IN FULL

This Separation Agreement and Release in Full (this "**Agreement**") is made and entered into by and between the City of Charlotte, a North Carolina Municipal Corporation ("**City**"), and Randall W. Kerrick ("**Employee**"). This Agreement is effective as of October 2, 2015 ("**Effective Date**").

PRELIMINARY STATEMENT

Employee was hired by City on or about March 22, 2010, and has worked most recently as a Charlotte Mecklenburg Police Officer. On September 18, 2013, Employee was suspended without pay. Subsequent to Employee's suspension, the City Manager made a determination, pursuant to a City Council resolution adopted December 12, 1977 and recorded at Resolutions Book 13, pages 141-142, that the City would not defend, or pay for the defense, of a civil lawsuit against Employee.

Employee and City now desire 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 exchange for the release provided by Employee below, and Employee's agreement with various covenants 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 for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employee and City, intending to be legally bound, hereby agree to the termination 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 termination from employment with City, effective as of **October 2, 2015** (the "**Termination Date**").

2. **No Admission of Liability or Wrongdoing.** This Agreement and the payments provided herein do not constitute an admission of any wrongdoing, unlawful conduct or liability by the City.

3. **Payments and Benefits Provided by City.** City agrees to pay or provide Employee with compensation, benefits and consideration under this Agreement as follows:

(a) **Back Pay.** City shall pay Employee back pay from the date of Employee's suspension up through and including the Termination Date, payable in one lump sum, gross payment, on October 16, 2015, in accordance with City's generally applicable policies and procedures.

said cause may be had without further notice.

Dated _____, 20___.

SIGNATURE: _____

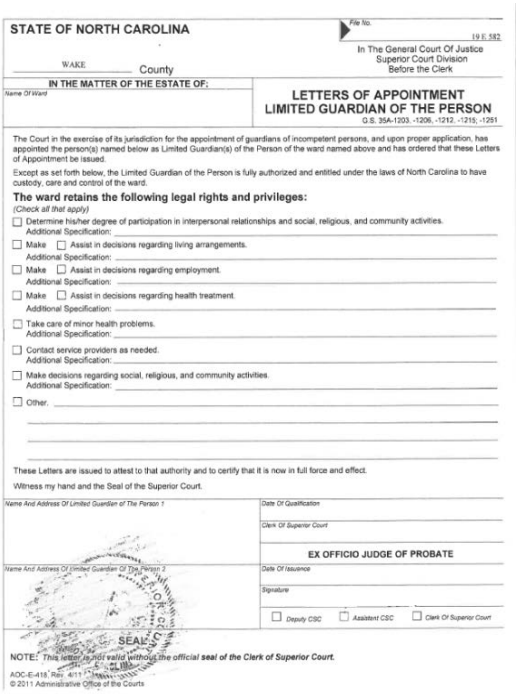
STATE OF _____)
)
County of _____)

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

Court Appointed Guardian



STATE OF NORTH CAROLINA

File No.

19 E 582

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

WAKE County

IN THE MATTER OF THE ESTATE OF:

Name Of Ward

LETTERS OF APPOINTMENT LIMITED GUARDIAN OF THE PERSON

G.S. 35A-1203, -1206, -1212, -1215, -1251

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:
- ☐ Contact service 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.

Name And Address Of Limited Guardian Of The Person 1 | Date Of Qualification

Clerk Of Superior Court

EX OFFICIO JUDGE OF PROBATE

Name And Address Of Limited Guardian Of The Person 2 | Date Of Issuance

Signature

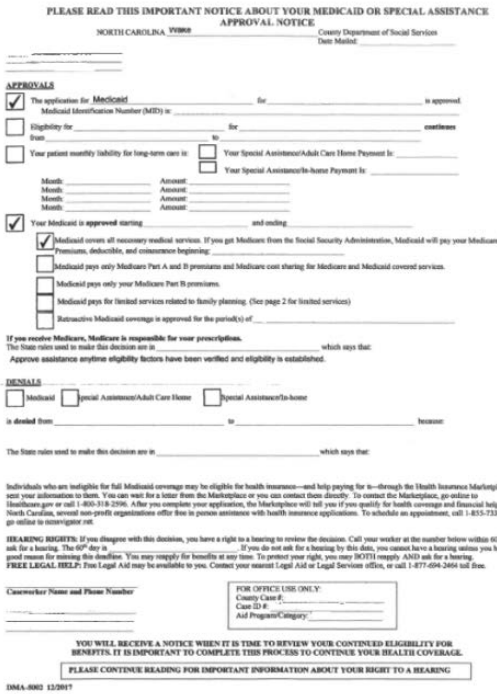
☐ Deputy CSC ☐ Assistant CSC ☐ Clerk Of Superior Court

SEAL

NOTE: *This letter is not valid without the official seal of the Clerk of Superior Court.*

AOC-E-418, Rev. 4/11
© 2011 Administrative Office of the Courts

Medicaid Approval Letter



PLEASE READ THIS IMPORTANT NOTICE ABOUT YOUR MEDICAID OR SPECIAL ASSISTANCE

APPROVAL NOTICE

NORTH CAROLINA WAKE County Department of Social Services

Date Mailed:

APPROVALS

☑ The application for Medicaid for is approved.

Medicaid Identification Number (MID) is:

☐ Eligibility for for continues from to

☐ Your patient monthly liability for long-term care is: ☐ Your Special Assistance/Adult Care Home Payment Is: ☐ Your Special Assistance/In-home Payment Is:

Month: Amount:
Month: Amount:
Month: Amount:
Month: Amount:

☑ Your Medicaid is **approved** starting and ending

☑ Medicaid covers all necessary medical services. If you get Medicare from the Social Security Administration, Medicaid will pay your Medicare A and B Premiums, deductible, and coinsurance beginning:

☐ Medicaid pays only Medicare Part A and B premiums and Medicare cost sharing for Medicare and Medicaid covered services.

☐ Medicaid pays only your Medicare Part B premiums.

☐ Medicaid pays for limited services related to family planning. (See page 2 for limited services)

☐ Retroactive Medicaid coverage is approved for the period(s) of

If you receive Medicare, Medicare is responsible for your prescriptions.

The State rules used to make this decision are in which says that:

Approve assistance anytime eligibility factors have been verified and eligibility is established.

DENIALS

☐ Medicaid ☐ Special Assistance/Adult Care Home ☐ Special Assistance/In-home

is **denied** from to because:

The State rules used to make this decision are in 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 sent your information to them. You can wait for a letter from the Marketplace or you can contact them directly. To contact the Marketplace, go online to Healthcare.gov or call 1-800-318-2596. 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 1-855-733-3711 or go online to ncnavigator.net.

HEARING RIGHTS: If you disagree with this decision, you have a right to a hearing to review the decision. Call your worker at the number below within 60 days to ask for a hearing. The 60th day is . If you do not ask for a hearing by this date, you cannot have a hearing unless you have a good reason for missing this deadline. You may reapply for benefits at any time. To protect your right, you may BOTH reapply AND 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 1-877-604-2464 toll free.

Caseworker Name and Phone Number

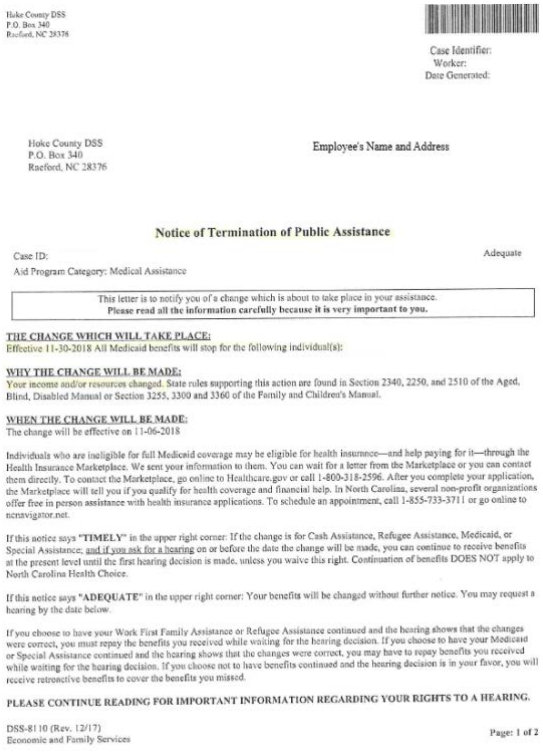
FOR OFFICE USE ONLY:
County Case #:
Case ID #:
Aid Program/Category:

YOU WILL RECEIVE A NOTICE WHEN IT IS TIME TO REVIEW YOUR CONTINUED ELIGIBILITY FOR BENEFITS. IT IS IMPORTANT TO COMPLETE THIS PROCESS TO CONTINUE YOUR HEALTH COVERAGE.

PLEASE CONTINUE READING FOR IMPORTANT INFORMATION ABOUT YOUR RIGHT TO A HEARING

DMA-8002 12/2017

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: Adequate

Aid Program Category: Medical Assistance

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 supporting this action are found in Section 2340, 2250, and 2510 of the Aged, Blind, Disabled Manual or Section 3255, 3300 and 3360 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 sent your information to them. You can wait for a letter from the Marketplace or you can contact them directly. To contact the Marketplace, go online to Healthcare.gov or call 1-800-318-2596. 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 1-855-733-3711 or go online to ncnavigator.net.

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 present 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.

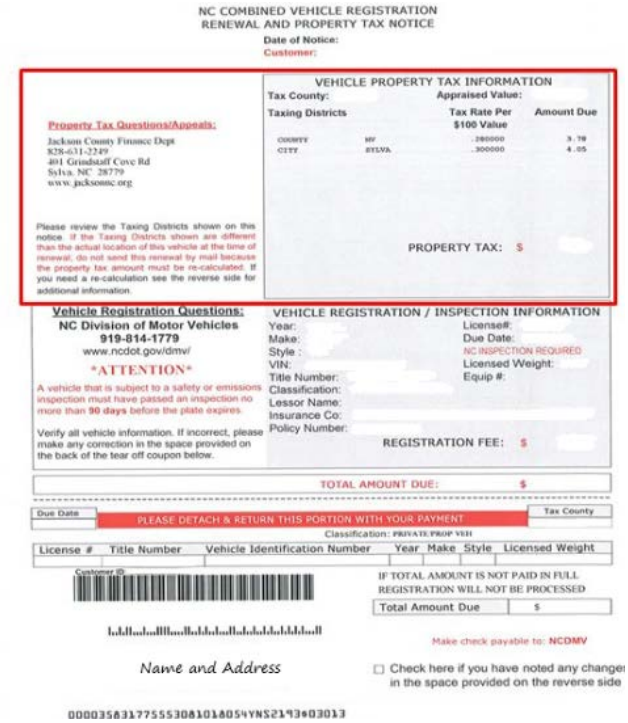
If you choose to have your Work First Family Assistance or Refugee Assistance continued and the hearing shows that the changes were correct, you must repay the benefits you received while waiting for the hearing decision. If you choose to have your Medicaid or Special Assistance continued and the hearing shows that the changes were correct, you may have to repay benefits you received while waiting for the hearing decision. If you choose not to have benefits continued and the hearing decision is in your favor, you will receive retroactive benefits to cover the benefits you missed.

PLEASE CONTINUE READING FOR IMPORTANT INFORMATION REGARDING YOUR RIGHTS TO A HEARING.

DSS-8110 (Rev. 12/17)
Economic and Family Services

Page: 1 of 2

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
COUNTY	MV	.280000	3.78
CITY	SYLVA	.300000	4.05

PROPERTY TAX: $

Property Tax Questions/Appeals:
Jackson County Finance Dept
828-631-2249
401 Grindstaff Cove Rd
Sylva, NC 28779
www.jacksonnc.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 renewal, do not send this renewal by mail because the property tax amount must be re-calculated. If you need a re-calculation see the reverse side for additional information.

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 #:
Classification:
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 PROP VEH

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

Customer ID

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

Total Amount Due $

Make check payable to: NCDMV

Name and Address

☐ Check here if you have noted any changes in the space provided on the reverse side

00003583177555308101805 4YNS2193+03013

Divorce Decree

NO. _____

IN THE MATTER OF THE MARRIAGE OF	§	IN THE DISTRICT COURT
	§	
	§	
JANE DOE	§	___ JUDICIAL DISTRICT
AND	§	
JOHN DOE	§	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.

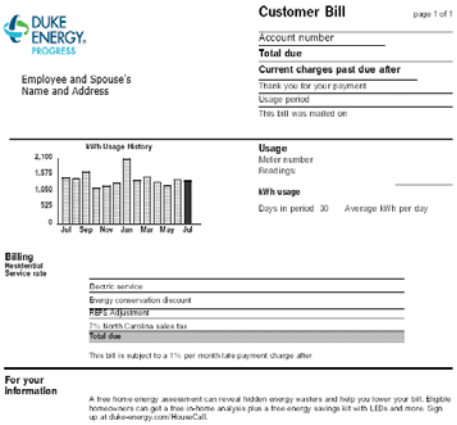
OR

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

Jurisdiction and Domicile

The Court finds that the pleadings of Petitioner are in due form and contain all the

Monthly Bill



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 #

Coverage Period Spring/Summer 2019

Dear

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 2019, whose coverage period is 01/01/2019 through 07/31/2019.

Now Eligible for Other Coverage Letter

[insert date]

[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]

Insurance Card w/ Effective Date