

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 <i>(may only be used to add dependents; cannot be used to drop dependents)</i>	
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. <i>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.</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
LEGAL MARRIED SPOUSE <i>Defined as legally married spouse, includes same and opposite gender spouses.</i>	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 <i>Defined as your biological child, includes child of same gender spouse.</i>	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 <i>Defined as your stepchild.</i>	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 <i>Defined as a child you have legally adopted, or has been placed with you for adoption or in anticipation of legal adoption.</i>	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 <i>Defined as your foster child or child placed with you for foster care.</i>	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 <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>	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) <i>Defined as any recognized child you are required to cover under the Plan due to a QMCSO.</i>	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.

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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



VERIFICATION OF FACTS FOR DEPENDENTS UNDER 6 MONTHS OF AGE



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

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. Kovich ("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 signed December 13, 1977 and recorded at Resolutions Book 13, pages 640-641, 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 several matters.

AGREEMENT

NOW, THEREFORE, in consideration of the agreements and representations hereinafter set forth, and the 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 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 termination 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 paid due after _____

Send me for your payment _____

Usage period _____

This bill was mailed on _____

Usage
Water number _____
Postings _____

Usage usage _____
Days in period 30 Average usage _____

Billing Breakdown of Service rate

Basic service _____



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/Comments: _____

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 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 rear of coupon below.

VEHICLE REGISTRATION / INSPECTION INFORMATION

Year: _____

Make: _____

Style: _____

VIN: _____

Title Number: _____

Classification: _____

Lessor Name: _____

Insurance Co: _____

Policy Number: _____

License #: _____

Due Date: _____

Due Date: NC INSPECTION REQUIRED

Licensed Weight: _____

Equip #: _____

REGISTRATION FEE: \$

TOTAL AMOUNT DUE: \$

Due Date: _____

PLEASE DETACH & RETURN THIS PORTION WITH YOUR PAYMENT

Classification: PRIVATE OR PUBLIC VEH

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: _____

Make check payable to _____

Check here if you have in the space provided

Name and Address

00003563377553081014054YNS2142403013



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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 report and 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 interest of the adoptee; (5) That the adoptee has resided with the petitioner since [date of adoption] [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 Superior Court of the District of Columbia] since [date of adoption].



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

Index No. _____

Plaintiff, _____

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.

1. Pursuant to DRL §240(1), this Qualified Medical Child Support Order (QMCSO) orders and directs that the unemancipated dependent 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 relation named herein is eligible, under the group health plan named herein in accordance with Section 609 of the Federal Employee Retirement Income Security Act.

2. The Participant (legally responsible relative) is:

Name: _____ Soc. Sec.#: _____ Mailing Address: _____

3. The Dependents' Custodial Parent or Legal Guardian who is to be provided with medical insurance cards and benefits claim forms on behalf of dependents:

Name: _____ Soc. Sec.#: _____

(From CTS-400 - Rev. 5/99)

4. The group health plan subject to this order is:



COURT APPOINTED GUARDIAN

STATE OF NORTH CAROLINA

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 ☐ 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: _____

☐ Consent 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.

Name and Address of Limited Guardian of the Person: _____

Signature of Limited Guardian: _____

Signature of Clerk: _____

EX OFFICIO JUDGE OF PROBATE

Signature of Judge: _____

NOTE: This document is subject to the official seal of the Clerk of Superior Court.

AD-004 (Rev. 10/11)

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LEASE AGREEMENT

This Lease Agreement (this "Agreement") is made this _____ day of _____, 20____, by and between _____ located at _____, AL, ("Landlord") and _____, ("Tenant") located at _____, AL. 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, 2018 County Department of Social Services (Date Mailed)

APPROVAL

☒ The application for Medicaid is approved for [] months.

☐ The application for Medicaid is denied for [] months.

☐ Your patient monthly liability for long-term care is [] Your Special Assistance/Adult-Care Home Payment is []

☐ Your Special Assistance/Refugee Payment is []

☒ 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 Medicare A and B premiums, deductibles, and coinsurance 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 the limited services)

☐ Alternative Medicaid coverage is approved for the period(s) of []

If you receive Medicaid, Medicaid is responsible for your prescription(s). The State will not make this decision on its [] which says that []

Personal assistance employee eligibility factors have been verified and eligibility is established.

REMARKS

☐ Medicaid ☐ Special Assistance/Adult-Care Home ☐ Special Assistance/Refugee

is denied from [] to [] because []

The State will not make this decision on its [] 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 want your information to help you decide what to do. 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 1-800-318-2796. 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 1-855-733-3711 or go online to navigator.nc.gov.

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 "OFF" date 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 request for benefits at any time. To protect your rights, you may SCOTS (Specialized Office of Tax and Social Security) call 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 1-877-686-2689 toll free.

County Name and Phone Number []

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

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

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

DHHS-000 01/2017



MEDICAID TERMINATION LETTER

Hoke County DSS
P.O. Box 340
Raeford, NC 28370

Case Identifier:
Work:
Date Generated:

Hoke County DSS
P.O. Box 340
Raeford, NC 28370

Employee's Name and Address

Notice of Termination of Public Assistance

Case ID: [] Adequate

Aid Program Category: Medicaid 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 regarding this action are found in Section 2340, 2290, and 2310 of the Adult, 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 11-30-2018.

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 want your information to help you decide what to do. 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 1-800-318-2796. 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 1-855-733-3711 or go online to navigator.nc.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 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 you were correct, you must stop the benefits you received while waiting for the hearing decision. If you choose to have your 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 shows that you were correct, you may receive 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.