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 3 for the list of acceptable documents.

Qualifying Life Events	Required Documentation from Employee
Adoption	Refer to chart on page 3.
Birth	Refer to chart on page 3.
Court Order (Court Orders may only be used to add dependents and cannot be used to drop dependents.)	Refer to chart on page 3.
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 3.
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. If you or your dependents change your country of permanent residence by moving to or from the United States a signed written statement documenting the event and proof of the date you or your dependent changed your county of permanent residence is required. **Please note:** Losing individual coverage doesn't qualify as a qualifying life event if you voluntarily drop coverage, if you lose coverage because you didn't pay your premiums, or if you lose coverage because you didn't provide required documentation when asked for more information.
Marriage (Employee)	Refer to chart on page 3.
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 3 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. If you or your dependents change your country of permanent residence by moving to or from the United States a signed written statement documenting the event and proof of the date you or your dependent changed your county of permanent residence is required
Return from Family and Medical Leave (FMLA)	Refer to chart on page 3 for additional requirements for adding a dependent.
Return from Leave of Absence	Refer to chart on page 3 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 3 below for additional requirements when adding a dependent.
Significant Change in Cost of Existing Coverage	See your HBR to process event. HBR must submit exception and materials provided by member to demonstrate cost increase. Refer to page 3 chart for additional requirements to add dependent. See benefit booklet for details.

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

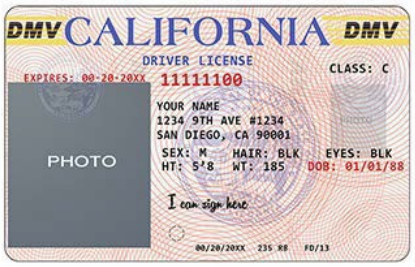
Dependent Verification Requirements	Required Documentation from Employee

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 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 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 1040EZ) as filed with the IRS**,** listing the child as dependent **OR** • Birth Certificate or Mother's Copy with subscriber's name listed as parent • Verification of Facts within 6 months of birth
Stepchild under the age of 26 *Defined as your stepchild.*	• Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A or 1040EZ) as filed with the IRS**,** listing the stepchild as 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 *Child you have legally adopted or has been placed with you for adoption or in anticipation of legal adoption.*	• Page 1 of subscriber's most recent Federal Income Tax Return* (1040, 1040A or 1040EZ) as filed with the IRS**,** listing the stepchild or adopted child as dependent **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 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 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

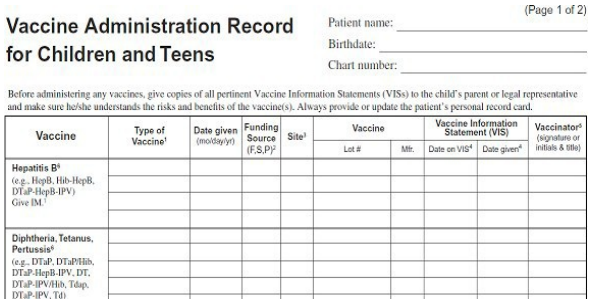
*Most recent tax form from the previous year. If not available, the year prior will be accepted along with a letter indicating you have an extension. **Employees that have been married less than a year are able to submit a marriage certificate only.

Unacceptable Documentation for Dependents:



Paternity Results

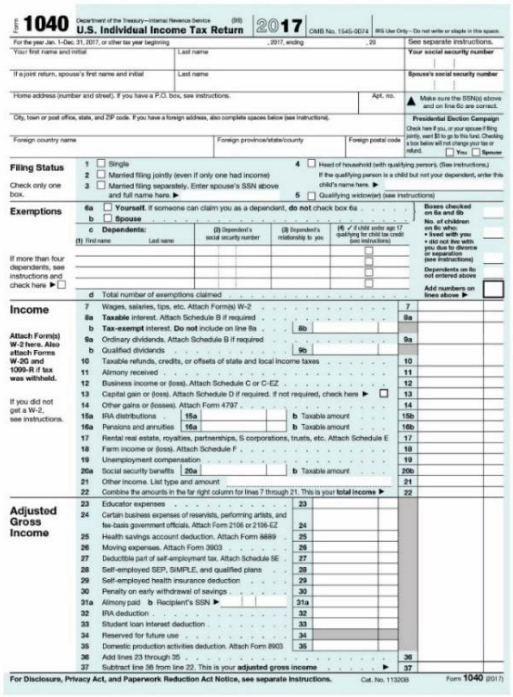
Birth Certificate Application



Immunization Records

Acceptable Documentation for Dependents:

1040 Tax Form



Form 1040 U.S. Individual Income Tax Return 2017

Department of the Treasury—Internal Revenue Service (99)

OMB No. 1545-0074

IRS Use Only—Do not write or staple in this space.

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

See separate instructions.

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

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

Home address (number and street). If you have a P.O. box, see instructions. | Apt. no.

Make sure the SSN(s) above and on line 6c are correct.

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

Presidential Election Campaign

Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. You Spouse

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

Filing Status Check only one box.

1 Single

2 Married filing jointly (even if only one had income)

3 Married filing separately. Enter spouse's SSN above and full name here.

4 Head of household (with qualifying person). (See instructions.) If the qualifying person is a child but not your dependent, enter this child's name here.

5 Qualifying widow(er) (see instructions)

Exemptions

6a Yourself. If someone can claim you as a dependent, do not check box 6a

b Spouse

Boxes checked on 6a and 6b

No. of children on 6c who:

• lived with you

• did not live with you due to divorce or separation (see instructions)

Dependents on 6c not entered above

Add numbers on lines above

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.

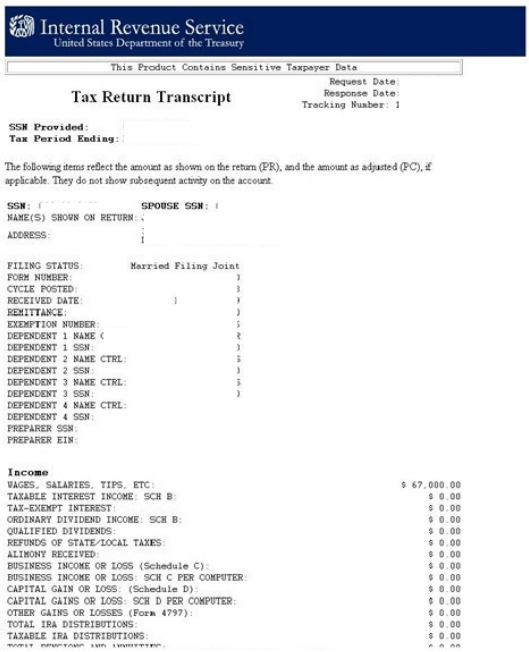
7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	
8a	Taxable interest. Attach Schedule B if required	8a	
b	Tax-exempt interest. Do not include on line 8a	8b	
9a	Ordinary dividends. Attach Schedule B if required	9a	
b	Qualified dividends	9b	
10	Taxable refunds, credits, or offsets of state and local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

Adjusted Gross Income

23	Educator expenses	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	
26	Moving expenses. Attach Form 3903	26	
27	Deductible part of self-employment tax. Attach Schedule SE	27	
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN	31a	
32	IRA deduction	32	
33	Student loan interest deduction	33	
34	Reserved for future use	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 35	36	
37	Subtract line 36 from line 22. This is your adjusted gross income	37	

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: 1

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.

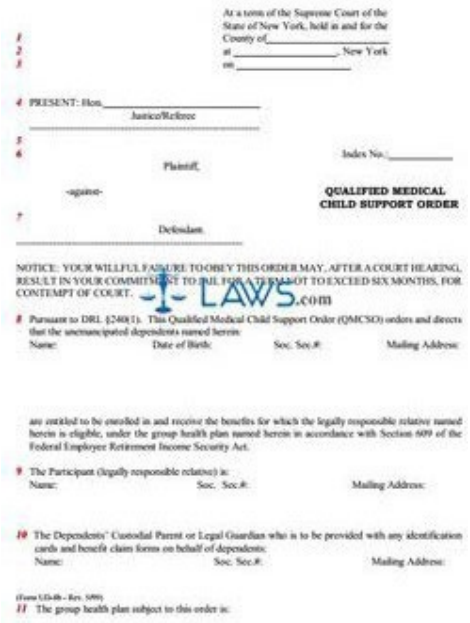
SSN: (SPOUSE SSN: (
NAME(S) SHOWN ON RETURN: ,
ADDRESS: ;
[

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

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-6b - 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.

JANUARY 01, 2000 — 156-00-199999
MANHATTAN — 01-03-00 — 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, Print
City Registrar

SAMPLE COPY

N00022594

The City of New York

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

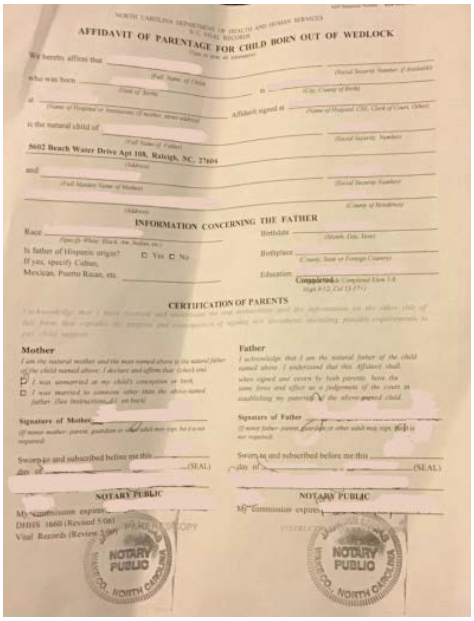
Current Legal Name (First) (Middle) (Last) 19.		
Date of Birth 20.	Place of Birth 21.	
Social Security Number 22.	Education 23.	
Hispanic Origin ? 24.	Race 25.	

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



AFFIDAVIT OF PARENTAGE FOR CHILD BORN OUT OF WEDLOCK

We hereby affirm that _____ (Full Name of Child) who was born _____ (Date of Birth) in _____ (City, County of Birth) at _____ (Name of Hospital or Institution) (If mother, street address) Affidavit signed at _____ (City, County of Birth) 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, American Indian, etc.) Birthdate _____ (Month, Day, Year)
Is father of Hispanic origin? ☐ Yes ☐ No
If yes, specify Cuban, Mexican, Puerto Rican, etc. _____ Birthplace _____ (County, State or Foreign Country)
Education _____ Completed (Circle Highest Grade Completed) 1-8 9-12 Col 13-17+

CERTIFICATION OF PARENTS

I acknowledge that I have received and understand the information on the other side of this form that explains the purpose and consequences of signing an acknowledgment, including possible requirements to pay child support.

Mother

I am the natural mother and the man named above is my 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 shall, when signed and sworn to, have the same force and effect as a judgment 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 NOTARY PUBLIC

Lease Agreement

Confirmation Statement

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.

DRAFT

[redacted]

Date Printed: 09/28/2020

Confirmation Statement — **SHP-State Retirement System**

[redacted]

Employing Unit Assigned ID [redacted]
Date of Hire: 01/01/2012
Gender: Female

Home Phone:
Work Email: [redacted]

Current Elections — Monthly Subscriber Costs: $50.00

[redacted] Relationship: Subscriber | Date of Birth: [redacted]

✓ 80/20 PPO Plan — Effective: 01/01/2020
Employee Only — **Monthly Cost $50.00 ***

* Costs have been reduced by $60.00 of benefit program allocations

Key

✓ Person is covered by the benefit
↻ The benefit coverage will be ending
⚠ Person is no longer covered by the benefit

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 _____

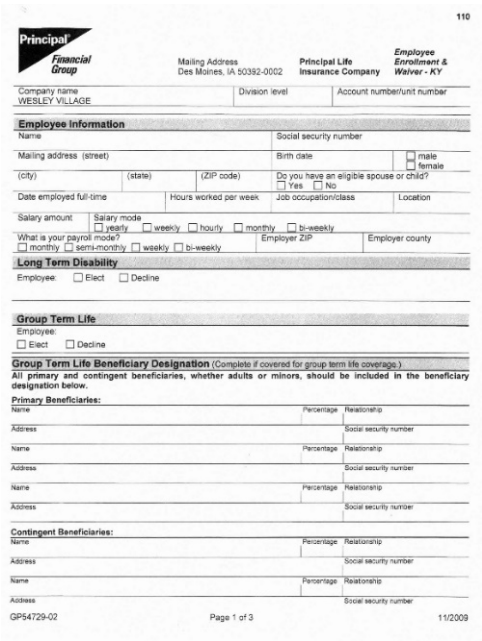
FINAL DECREE OF ADOPTION

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 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 [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.

1

Beneficiary Designation



110

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
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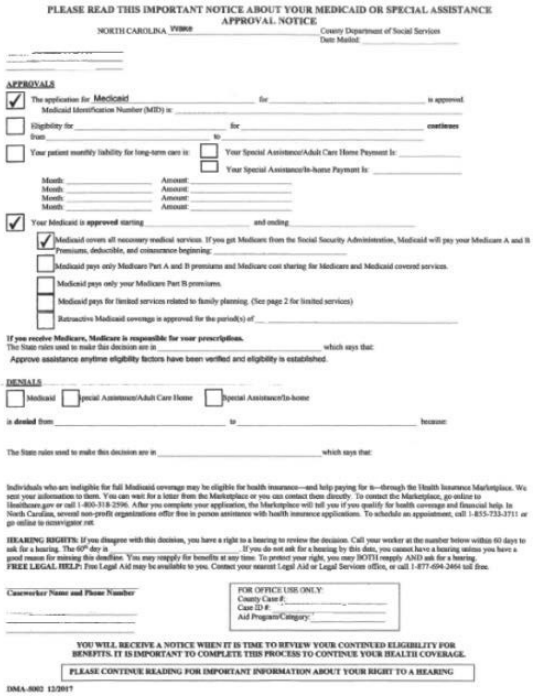
Medicaid Approval Letter



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

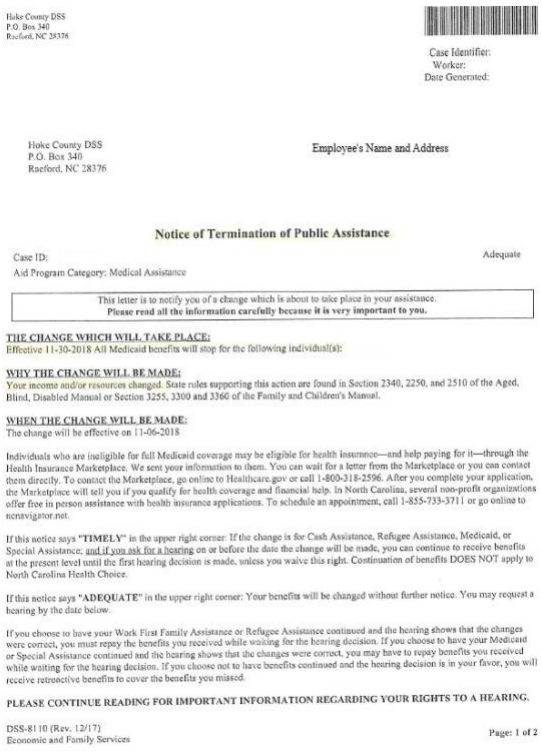
FOR OFFICE USE ONLY:
County Case #:
Case ID #:
Aid Program/Category:

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:

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 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: $

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 change in the space provided on the reverse side

00003583177555308101805+YNS2193+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.

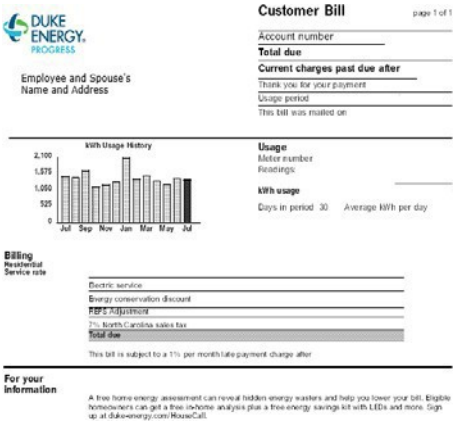
OR

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]

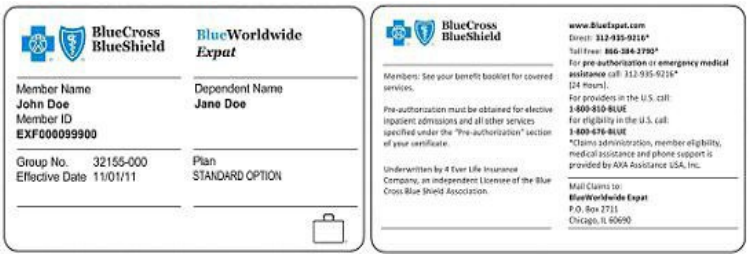
My signature on this letter certifies that the above information is true and correct as of the date of this letter. If you require any additional information, please contact me at [insert email address] or [insert phone number, with extension if applicable].

Regards,

[Signature]

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

Insurance Card w/ Effective Date



Please note: See your benefit booklet for further details.