Children or Spouse Dependent Eligibility Documentation Requirement

Verifying Dependent Eligibility

HBRs are required to administer the eligibility as it is set forth in Statute. Dependent eligibility verification is part of this requirement.

- The HBR is responsible for verifying the dependent eligibility of the State employee.
- Employees are required to provide documentation to verify their dependent's eligibility within 30 days of their hire date.

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Dependent Eligibility Verification – Page 2

The following documents should be reviewed to verify eligibility for the following dependent types before the dependent is enrolled in the Plan:

Spouse • Page 1 of the most current year tax return listing the spouse or: • Marriage certificate with one of the following: • Current utility billing statement listing the employee and spouse • Designation of spouse as primary beneficiary of the employee's life insurance	Adopted Child(ren)/Legal Guardianship • Page 1 of the most current year tax return listing the child(ren) or: • Court documents signed by a judge showing that the employee has adopted the child or legal guardianship • Papers from the adoption agency showing intent to adopt
Biological Child(ren) • Page 1 of the most current year tax return listing the child(ren) or: • Birth Certificate	Foster Child(ren) • State of North Carolina Certification identifying the child by name and setting forth all relevant aspects of the relationship. The Certification of Dependent Eligibility form (P4) and a copy of a document that establishes a bona-fide foster child relationship are required.

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Any required dependent eligibility documentation must be attached to the enrollment form at the time the enrollment form is turned in for processing of coverage. Enrollment forms will not be processed without proper dependent eligibility documentation. It is the responsibility of the employee to provide this information to the employer. It is also the responsibility of the employee to return the enrollment form and the proper dependent eligibility documentation to the employer within 30 days of their hire date.

_____ _____

Employee Signature Date

BlueCross BlueShield of North Carolina

State Health Plan for Teachers and State Employees
www.shpnc.org

North Carolina HEALTH Smart

CHANGE FORM

PLEASE TYPE OR PRINT CLEARLY IN BLUE OR BLACK INK. DO NOT WRITE IN SHADED AREAS.

1. SUBSCRIBER/MEMBER ID NO. | SOCIAL SECURITY NUMBER | LAST NAME | FIRST | INITIAL | ☐ PLEASE SEND ID CARD

2. ☐ CHANGE MY ADDRESS TO — STREET - ROUTE NO./BOX NO. | CITY | STATE | ZIP

3. ☐ NAME CHANGE — LAST NAME | FIRST | INITIAL | BECAUSE OF ☐ MARRIAGE ☐ LEGAL CHANGE | ☐ HOME PHONE NUMBER — —

4. ☐ CORRECT MY BIRTHDATE TO — MO. | BIRTHDATE | YEAR | ☐ CHANGE MY MARITAL STATUS TO ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED | CANCEL COVERAGE ☐ I WISH TO CANCEL COVERAGE.

5. ☐ CHANGE MY COVERAGE TO ☐ EMPLOYEE ONLY ☐ EMPLOYEE-CHILD/REN ☐ EMPLOYEE-SPOUSE ☐ EMPLOYEE-FAMILY | COMPLETE IF YOUR SPOUSE IS A TEACHER OR STATE EMPLOYEE | NAME OF SPOUSE | ID NUMBER

6. ☐ REMOVE, CHANGE OR ADD DEPENDENTS — ☐ REMOVE ☐ CHANGE ☐ ADD MY ☐ SPOUSE ☐ DEPENDENT CHILD/REN

REASON AND DATE OF EVENT REQUIRED

☐ MARRIAGE ___/___/___ ☐ STUDENT ___/___/___ ☐ FMLA/MILITARY ___/___/___
☐ SEPARATION ___/___/___ ☐ NEWBORN ___/___/___ ☐ MAXIMUM AGE 26 ___/___/___
☐ DIVORCE ___/___/___ ☐ STEPCHILD ___/___/___ ☐ OTHER _____
☐ DEATH ___/___/___ ☐ FOSTER CHILD ___/___/___

7. ☐ REMOVE DEPENDENTS — ADDRESS (IF DIFFERENT FROM YOURS) STREET - ROUTE NO./BOX NO. | CITY | STATE | ZIP | COUNTY

DEPENDENT INFORMATION → List dependents to be added or removed. List additional children to be added on a separate form.

	NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD IS MY	COMPLETE ONLY IF CHILD IS OVER 19	MEDICARE ELIGIBLE?	DOES WAITING PERIOD APPLY?
8. ☐ REMOVE ☐ ADD	SPOUSE		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE			☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO
9. ☐ REMOVE ☐ CHANGE ☐ ADD	CHILD 1		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 12) ☐ HANDICAPPED	☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO
10. ☐ REMOVE ☐ CHANGE ☐ ADD	CHILD 2		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 12) ☐ HANDICAPPED	☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO
11. ☐ REMOVE ☐ CHANGE ☐ ADD	CHILD 3		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 12) ☐ HANDICAPPED	☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO

12. IF FULL-TIME STUDENT, LIST DEPENDENT'S NAME AND ACCREDITED INSTITUTION.

MEDICARE INFORMATION List below yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

	NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO	EFFECTIVE DATE ENROLLED	
13.			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	PART A (MM/DD/YY): ___/___/___	PART B (MM/DD/YY): ___/___/___
14.			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	PART A (MM/DD/YY): ___/___/___	PART B (MM/DD/YY): ___/___/___

15. **OTHER GROUP HEALTH COVERAGE** — COMPLETE THE PRIOR COVERAGE/OTHER COVERAGE INFORMATION FORM IF YOU OR YOUR DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE IN ADDITION TO THE STATE HEALTH PLAN THAT WILL REMAIN IN EFFECT AFTER THE EFFECTIVE DATE OF THIS FORM, OR IF YOU OR YOUR DEPENDENTS HAD OTHER COVERAGE THAT ENDED WITHIN THE PAST 63 DAYS.

16. COMMENTS

EMPLOYEE AUTHORIZATION

I hereby apply for the changes, adjustments and/or additions to my enrollment listed on the form above and I agree that all information provided is correct. I further agree that we shall abide by the provisions of the Agreement for the selected plan option.

I hereby authorize my employer to deduct from my earnings any deduction for the coverage elected above.

DESIRED EFFECTIVE DATE OF CHANGE ___ (MONTH) 01 (DAY) ___ (YEAR)

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____

EMPLOYING UNIT MUST COMPLETE

EMPLOYING UNIT NAME	EXPEDITE? ☐ NO ☐ YES
GROUP NO.	HIRE DATE
PAYROLL NO.	DEPARTMENT NO.
DOES MEDICARE REDUCED RATE APPLY? ☐ NO ☐ YES	
EMPLOYEE DEDUCTION $	EFFECTIVE DATE
EMPLOYER CONTRIBUTION $	01

C48, 6/10 PINK COPY should be retained by the employee and used as a temporary ID card Submit WHITE and YELLOW COPY to employing unit