Print Form

Health Choice Extended Coverage
DMA Budget Management
2501 Mail Service Center
Raleigh, N.C. 27699-2501

_____
_____
_____

Case ID Number: _____

Date:

Dear Former NC Health Choice Member,

Health Choice insurance coverage ended on _____ for the child/children listed below because of no longer being eligible. You can purchase extended Health Choice coverage for up to 12 consecutive months by paying a monthly premium directly to NC Health Choice in the amount of $**187.01 per child.**

If you want to purchase extended coverage, please check the appropriate box below for each child you want to cover. You must date, sign and return this letter in the enclosed envelope. When we receive this notice with your selection(s), we will send a bill for the amount due. After the first bill, you will then be billed monthly.

This will be your only notice. If we do not receive your response regarding interest in enrolling one or more children in extended coverage within 30 days from the date of this letter, we will not activate enrollment in extended coverage and your child or children will no longer have Health Choice insurance coverage as of _____.

Extended coverage purchased will be cancelled when any of the following situations occur:

1. The 12-month continuation period ends.
2. A child obtains other comprehensive health insurance coverage.
3. The monthly premium is not paid within 90 days of the NC Health Choice cancellation date and each subsequent monthly premium is not paid within 30 days of the date of each invoice.
4. The covered child turns age 19 (coverage will be cancelled effective the first calendar day of the month after the month in which the child turns 19).
5. The NC Health Choice program no longer provides extended NC Health Choice.

Your response must be received by the Health Choice administrator by the 30th calendar day after the date of this letter _____. Please contact Deborah Harris at 919-855-4218 if you have any questions concerning your payment. Please contact your local County Department of Social Services or 919-855-4000 if you have questions about your eligibility for NC Health Choice extended coverage, NC Health Choice, or Medicaid.

Sincerely,
Barry Brown
DMA Budget Management

☐ I wish to purchase extended coverage for up to 12 months by paying the monthly premium of **$187.01** for **each child** I have checked below:

☐ Child name _____
☐ Child name _____
☐ Child name _____
☐ Child name _____
☐ Child name _____
☐ Child name _____

SEND NO MONEY NOW – YOU WILL RECEIVE A BILL FOR THE COVERAGE YOU HAVE SELECTED.

Signature: _____ Date: _____
Responsible party

DMA-3701 Revised 4/22/2014