§115 OPEB Trust - Medical and/or Vision Premium Expense Reimbursement Request

DATE RANGE From 6/30/2019
To 12/31/2019

RETRIEE INFORMATION:

Name: [redacted]

Employee #: 50424

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
8-10-19	Medicare Part B	S.S.A.	135 50	135 50
7-15-19	Medicare Sup Plan G	Mutual of Omaha	115 24	115 24
9-10-19	Medicare Part B	S.S.A.	135 50	135 50
8-15-19	Medicare Sup Plan G	Mutual of Omaha	115 24	115 24
10-10-19	Medicare Part B	S.S.A.	135 50	135 50
9-16-19	Medicare Sup Plan G	Mutual of Omaha	121 00	121 00
11-10-19	Medicare Part B	S.S.A.	135 50	135 50
10-15-19	Medicare Sup Plan G	Mutual of Omaha	121 00	121 00
12-10-19	Medicare Part B	S.S.A.	135 50	135 50
11-15-19	Medicare Sup Plan G	Mutual of Omaha	121 00	121 00
1-10-20	Medicare Part B	S.S.A.	135 50	135 50
12-16-19	Medicare Plan G	Mutual of Omaha	121 00	121 00
			$0.00	

Medicare Eligible? X YES ____ NO

Total 1527 48

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 1-31-2020

OPEB Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: OPEB c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

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In order for an eligible recipient to receive reimbursement of medical insurance premiums from the Post Retirement Medical Plan & Trust, the eligible participant must submit at least one of the following as proof of payment for the medical insurance premiums:

- A copy of the invoice from the insurance company and copy of the receipt of payment;
- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
- A copy of a pay stub if the pay stub clearly shows a deduction for medical insurance on a post-tax basis;
- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages on a post-tax bas
- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Social Security Administration

Date: January 31, 2020

[redacted]

[redacted]

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Current Social Security Benefits

Beginning December 2019, the full monthly Social Security benefit before any deductions is [redacted]

We deduct $144.60 for medical insurance premiums each month.

Medicare Part B New Amount for 2020

The regular monthly Social Security payment is [redacted].
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the second Wednesday of each month.

Information About Past Social Security Benefits

From December 2018 to November 2019, the full monthly Social Security benefit before any deductions was [redacted]

We deducted $135.50 for medical insurance premiums each month.

The regular monthly Social Security payment was [redacted]
(We must round down to the whole dollar.)

Type of Social Security Benefit Information
You are entitled to monthly retirement benefits.

[redacted]

Medicare Information
You are entitled to hospital insurance under Medicare beginning June 2018.

You are entitled to medical insurance under Medicare beginning June 2018.

[redacted]

If you have any questions, please log onto Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

Suspect Social Security Fraud?
Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions
We invite you to visit our web site at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local office at 800-772-1213. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
1170 HARVARD WAY

Policy Info

Policy Payor	[redacted]
Issue Date	**09/01/2018**
Paid to Date	**02/01/2020**

Payment Details

Date Processed	07/15/2019
Amount Paid	**$115.24**

Generated: 01/31/2020 09:11 AM

Policy Info

Policy Payor	[redacted]
Issue Date	**09/01/2018**
Paid to Date	**02/01/2020**

Payment Details

Date Processed	08/15/2019
Amount Paid	**$115.24**

Generated: 01/31/2020 09:12 AM

Policy Info

Policy Payor	[redacted]
Issue Date	**09/01/2018**
Paid to Date	**02/01/2020**

Payment Details

Date Processed	09/16/2019
Amount Paid	**$121.00**

Generated: 01/31/2020 09:13 AM

Policy Info

Policy Payor	[redacted]
Issue Date	**09/01/2018**
Paid to Date	**02/01/2020**

Payment Details

Date Processed	10/15/2019
Amount Paid	**$121.00**

Generated: 01/31/2020 09:14 AM

Policy Info

Policy Payor	[redacted]
Issue Date	**09/01/2018**
Paid to Date	**02/01/2020**

Payment Details

Date Processed	11/15/2019
Amount Paid	**$121.00**

Generated: 01/31/2020 09:14 AM

Policy Info

Policy Payor	[redacted]
Issue Date	**09/01/2018**
Paid to Date	**02/01/2020**

Payment Details

Date Processed	12/16/2019
Amount Paid	**$121.00**

Generated: 01/31/2020 09:15 AM