Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

TRUCKEE MEADOWS
APR 06 2020
WATER AUTHORITY

DATE RANGE From January 1, 2020
To March 31, 2020

RETIREE INFORMATION:

Name: [redacted]

Employee #: [redacted]50068

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
Jan. - March	Monthly Premium	Medicare "Part B"	$144.60 per month X three months	$433.80 -
				$0.00 -
				$0.00 -
				$0.00 -
				$0.00 -
				$0.00 -
				0.00
			Total	$433.80 -

Medicare Eligible? X YES ____NO

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, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) 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: 4/3/20

PRMPT 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.

Social Security Administration

Date: April 03, 2020
[redacted]
REF: A

[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"

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 fourth 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]