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

DATE RANGE From 1-20
To 3-20

RETIREE INFORMATION:

Name: [redacted]

Employee #: _____

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
1-5-20	Monthly premium	Medicare	144.60	$ 144.60 -
2-5-20	"	"	"	$ 144.60 -
3-5-20	"	"	"	$ 144.60 -
				$ -
				$ -
				$ -

Medicare Eligible? ✓ YES ____ NO

Total $ 0.00 433.80

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:** 1-28-20

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.

Return completed form to: PRMPT 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.

Your New Benefit Amount

BENEFICIARY'S NAME: [redacted]

Your Social Security benefits will increase by **1.6%** in 2020 because of a rise in the cost of living. You can use this letter as proof of your benefit amount if you need to apply for food, rent, or energy assistance. You can also use it to apply for bank loans or for other business. Keep this letter with your important financial records.

How Much Will I Get And When?

- Your monthly amount (before deductions) is [redacted]
- The amount we deduct for Medicare Medical Insurance is $144.60
  (If you did not have Medicare as of November 22, 2019, or if someone else pays your premium, we show $0.00.)
- The amount we deduct for your Medicare Prescription Drug Plan is $0.00
  (We will notify you if the amount changes in 2020. If you did not elect withholding as of November 1, 2019, we show $0.00.)
- The amount we deduct for voluntary Federal tax withholding is [redacted]
  (If you did not elect voluntary tax withholding as of November 22, 2019, we show $0.00.)
- After we take any other deductions, you will receive [redacted]

on or about January 8, 2020.

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. Or visit ***www.ssa.gov/non-medical/appeal*** to appeal online. We would be happy to review the amounts.

If you receive a paper check and want to switch to an electronic payment, please visit the Department of the Treasury's Go Direct website at ***www.godirect.org*** online.

What If I Have Questions?

- Visit our website at ***www.socialsecurity.gov***
- Call us toll-free at **1-800-772-1213** (TTY **1-800-325-0778**)
- Contact your nearest Social Security office

1170 HARVARD WAY
RENO NV 89502

Other Help For Seniors

Call the Eldercare Locator service of the U.S. Administration on Aging at **1-800-677-1116** or visit ***www.eldercare.acl.gov*** to learn about a wide variety of services that may be helpful to you.