SANTA MONICA POLICE OFFICERS' REIMBURSEMENT BENEFIT TRUST
1200 Wilshire Boulevard, 5th Floor, Los Angeles, CA 90017
Telephone (562) 463-5050 • FAX (562) 463-5894 • Email to smpoatrust@bpabenefits.com

ANNUAL RETIREE MEDICAL PLAN OPT-OUT FORM

If you and your family have no intention of applying for and receiving a premium assistance tax credit through a Qualified Health Plan under a state or federal health insurance Exchange, NO action is required.
If you and/or a family member are already receiving such a Tax Credit, you must **complete and return this form within 30 calendar days from the date of the letter, accompanying this form.**

1. Are you or your dependents eligible for or enrolled in Medicare? ☐ Yes ☐ No

If so, whom? _____

Effective date of that person's enrollment under Medicare: _____

2. Will you or your dependents enroll in a Qualified Health Plan under a state of federal health insurance Exchange (Exchange) as set out under the Patient Protection and Affordable Care Act (PPACA)? ☐ Yes ☐ No

If so, whom? _____

Effective date of that person's enrollment under the Exchange: _____

3. If the answer to no. 2 above is "Yes", are you or any of your dependents receiving, or eligible to receive a Tax Credit? ☐ Yes ☐ No

4. If the answers to no(s). 2 and 3 are "Yes," I agree that I (and my dependents) are opting out of receiving reimbursements under the Trust this year.

Also, I understand and acknowledge that if I, or any of my dependents, elect to receive benefits through a Qualified Health Plan under the Exchange and receive a Tax Credit that I must "**opt out"** of those benefits under the Trust for the full year in which I receive a Tax Credit. And as a result, my Trust benefits will be terminated until the end of the year in which I or my dependents receive a Tax Credit.

If you have checked "Yes" to questions 2 or 3 above, you must return this form to the Administrative Office at the address or fax number above within 30 calendar days of enrolling in the Exchange.

_____
Name (print)

_____
Address City State Zip Code

_____ _____
Signature Date

Note: If you and/or your dependents enroll in the Exchange and receive a Tax Credit at a later time, you must inform the Trust immediately. Please complete this form and return it to the Administrative Office at the address listed below. When enrolled, you and your dependents will not be eligible to receive any reimbursements from the Trust for the entire year. The Trust will be entitled to offset (or recoup) any reimbursements that were otherwise paid to you.

If you have any questions regarding this Opt-out provision, please contact the Administrative Office at the above telephone number.