SANTA MONICA POLICE OFFICERS' REIMBURSEMENT BENEFIT TRUST
1200 Wilshire Boulevard, 5th Floor, Los Angeles, CA 90017
Telephone (562) 463-5050 • FAX (562) 463-5993 • Email to smpoa@bpabenefits.com

To: Eligible Retirees of the Santa Monica Police Officers' Association Reimbursement Trust

From: Administrative Office

Date: December 2019

Subject: Required 2020 Annual Verification for Automatic Quarterly Reimbursement

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Automatic Quarterly Reimbursement is available to members who have their health insurance premium payroll deducted from their CalPERS Benefit Warrant Statements (pension check stubs), and their monthly premium equals or exceeds their reimbursement amount under the Trust. Verification and authorization is required annually in January or early February. As you were enrolled in this program in 2019, you must now provide the necessary documentation for that year and for 2020 by:

1. Completing and sign the enclosed form; and

2. Returning the form to our office **along with copies of each of your CalPERS Benefit Warrant Statements (pension check stubs) from February 2019 through January 2020**, showing your health plan premium deduction.

We ask that these documents be returned to our office no later than **February 20, 2020,** to avoid a delay in the processing of your reimbursement. Remember that an administrative fee of $25 will be deducted from each quarterly claims submission unless your enrollment is verified by providing the documents above.

Should you have any questions please call our office at 562-463-5050.

Thank you.

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REIMBURSEMENT CLAIM VERIFICATION FORM

Plan Participant Name:

_____
(PRINT NAME)

Spouse and/or Dependent's Name: _____

Participant's Address: _____

Daytime Phone: _____

Email: _____

***PLEASE* keep the Trust Administrator up-to-date on any change in the above contact information.**

1. Election of Coverage(s). As a member of the Retiree Medical Plan of the Santa Monica Police Officers' Association Reimbursement Trust, I hereby request to participate in the 2020 Automatic Quarterly Reimbursement program, and agree to comply with all submission requirements in order to continue in the program.

2. Reimbursement. I understand that by signing and submitting this form the Trust will continue to make quarterly payments directly to me as reimbursement for my health insurance premium payments. I understand that I must provide copies of all CalPERS Benefit Warrant Statements (pension check stubs) at the beginning of each new calendar year in order for the Trust to verify that I was correctly reimbursed. In other words, I must provide copies of all of my 2019 CalPERS check stubs in January or early February 2020. If my premium payments change or terminate, for any reason, it is my obligation to promptly advise the Trust of same. If I fail to do so, I agree to reimburse the Trust for any overpayments, as well as to pay the Trust for penalties, loss of interest earned, and attorney's fees and costs, if so incurred.

3. Annual Verification. I understand that the premium reimbursement will not continue until I have completed and signed this form and submitted proof of deductions as required by the Plan and returned it to the Administrative Office.

I understand that I am required to furnish verification annually or more frequently, if needed, as determined by the Trustees. I will be asked to verify that I remain covered by the same health insurance and that policy was paid for by payroll deduction from my CalPERS Benefit Warrant Statement (pension check stub).

I am enrolled in the following CalPERS Plan and attached is proof of that premium being deducted from my CalPERS Benefit Warrant Statement (pension check stub).

NAME OF HEALTH INSURANCE PLAN(s):

_____

My 2020 monthly health insurance premium is $_____

Other 2020 monthly health insurance premium is $_____

Total 2020 monthly health insurance premiums is $_____

4. I understand that I am responsible for all premium payments to the health insurance plan and that the Trust will reimburse me upon proof of my payment to the health insurance plan.

5. I understand that Reimbursement will be available only for the "Premium" as defined in Article I, section 1.16 of the Plan, up to the Reimbursement Amount described in Article III, section 3.2 of the Plan.

6. I agree to notify the Trust within thirty (30) days of any termination or any reduction in insurance premium payable below my benefit amount (as described in Article III, section 3.2 of the Plan) through my CalPERS Benefit Warrant Statement (pension check stub).

7. By my signature below, I am attesting to the Trust that I do not expect any change in my insurance coverage or my payroll deduction from my CalPERS Benefit Warrant Statement (pension check stub) for the year in which this verification is authorized.

8. I also agree to indemnify and reimburse the Trust on demand for any liability it may incur for failure to withhold federal, state or local income tax from any Reimbursement I receive for a non-qualifying medical expense or premium up to the

amount of additional tax owed by me. For example, a non-qualifying medical expense or premium is an expense that does not qualify as a Premium under Article I, section 1.16 of the Plan.

9. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent, or misleading information provided, i.e. failure to advise the Trust of my termination or reduction of insurance coverage, change in insurance premium, and/or suspension of payroll deductions.

I certify under penalty of perjury that the information I have given above is true and correct, that I have read, understood, and agree to the terms set out above in this form.

_____	_____
Participant's Signature	Date
_____	_____
Administrative Representative Approval	Date Approved