California Teachers Association Employees' Health & Welfare Benefits Trust

c/o Zenith American Solutions, Inc.
2250 S RANCHO RD. STE 295 | LAS VEGAS NV 89102-4454
Toll Free: (888) 243-2325 |Local Area: (650) 718-1293 |Fax: (650) 331-3920

Mail Date

«First_Name» «Last_Name»
«ADDRESS1»
«ADDRESS2»
«City» «State» «Zip_Code»

Re: California Teachers Association Employees' Health and Welfare Benefits Trust
Medicare Part B Premium Reimbursement

Dear «First_Name» «Last_Name»

Our records show that you are eligible for the Medicare Part B Premium Reimbursement program under the California Teachers Association Employees' Health and Welfare Benefits Trust ("Trust"). This letter and the enclosed materials explain the claims process for the Medicare Part B Premium Reimbursement program under the Trust. The claims process involves a **one-time** requirement to submit a completed Medicare Part B Premium Reimbursement Affidavit (copy enclosed) and supporting documentation.

IMPORTANT REIMBURSEMENT INFORMATION

To begin receiving the Part B Premium Reimbursement, an Eligible Retiree or Surviving Spouse must complete the enclosed affidavit and return it with a copy of their Medicare Health Insurance enrollment card issued by the Social Security Administration and/or if applicable, any eligible dependent's Medicare card**. Sample Medicare card enclosed – the card must have your unique Medicare Number.**

Please be aware that your monthly benefit reimbursements, which are paid quarterly, will be temporarily suspended if the Trust Office does not receive your response within 30 days from the date of this letter.

If you have any questions, please contact the Trust Office at 888.243.2325.

Sincerely,

The Trustees for the California Teachers Association Employees' Health and Welfare Benefits Trust

Enclosures:
Medicare Part B Premium Reimbursement Policy
Medicare Part B Premium Reimbursement Affidavit
Medicare Part B Premium Reimbursement Direct Deposit Authorization (optional)

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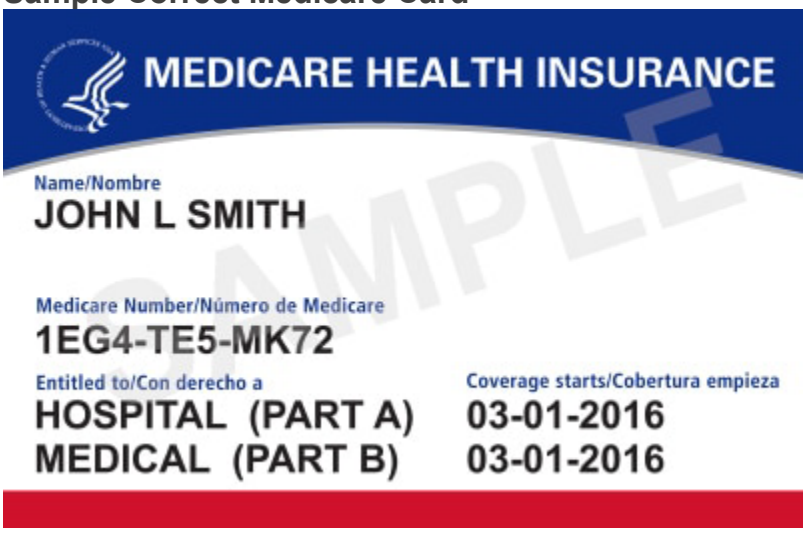
Self-Addressed Return Envelope

Important:
To begin receiving the Part B Premium Reimbursement, an Eligible Retiree and/or Surviving Spouse must complete the enclosed affidavit and return it with a copy of their Medicare Health Insurance enrollment card issued by the Social Security Administration and/or if applicable, any eligible dependent's Medicare card.

Sample Correct Medicare Card



Your card has a Medicare number that's unique to you — it's not your Social Security Number. This helps protect your identity. **We must have the correct Medicare card with your unique Medicare Number and not your Social Security Number to process your reimbursement without delay**.

Please send your completed Medicare Part B Premium Reimbursement Affidavit and supporting documentation to the following address:

California Teachers Association Employees' Health & Welfare Benefits Trust
c/o Zenith American Solutions
2250 S Rancho Rd. Ste. 295
Las Vegas, NV 89102-4454

If you have any questions, please contact the Trust Office at 888.243.2325.

Sincerely,

ATTACHMENT 1

THE CALIFORNIA TEACHERS ASSOCIATION
EMPLOYEES' HEALTH AND WELFARE BENEFITS TRUST

MEDICARE PART B PREMIUM REIMBURSEMENT AFFIDAVIT

1. I certify that, based on my eligibility for health coverage under the California Teachers Association Employees' Health and Welfare Benefits Trust ("Trust"), I am eligible to receive reimbursement for the amount of the standard monthly premium for Medicare Part B coverage, as adjusted annually by the Social Security Administration, for myself, and, if applicable, my eligible dependent(s), from the Trust (the "Part B Premium Reimbursement").

2. I certify that I (and/or my eligible dependent(s)) am enrolled in Medicare Part B and paying monthly Medicare Part B premiums, including, if applicable, by having such premium deducted from my and/or my eligible dependent's monthly Social Security benefit payment.

3. I further certify that I have attached hereto a true and correct copy of my, and/or my eligible dependent's Medicare Health Insurance enrollment card(s) issued by the Social Security Administration.

4. I understand that my, and/or my dependent's, eligibility for the Part B Premium Reimbursement will cease as of the earliest date I or my dependent are no longer: (i) enrolled in Medicare Part B, (ii) paying a Medicare Part B premium, or (iii) eligible for health coverage under the Trust. I agree that if I (and/or my eligible dependent) cease to be eligible for the Part B Premium Reimbursement, I will notify the Plan Administrator within 30 days. I further agree to repay, in the time and manner determined by the Plan Administrator, any amount paid to me after I and/or my eligible dependent(s) cease to be eligible to receive the Part B Premium Reimbursement.

5. I certify under penalty of perjury, that all the above statements are true and correct to the best of my knowledge and belief. I understand that a false statement or falsified Medicare Health Insurance enrollment card may permanently disqualify me from eligibility for the Part B Premium Reimbursement, and that the Trust shall have the right to recover any amounts paid to me because of such false statement or falsified Medicare Health Insurance enrollment card.

Retired Participant Signature: x _____

Retired Participant Name (please print) _____

SSN (last 3 digits) XXX-XX-X _____

Date of Birth (MM/DD/YYYY) _____

Medicare Part B Enrollment Date _____

Participant Date of Death (if applicable) _____

Spouse, Surviving Spouse or Dependent Signature: x _____

Spouse, Surviving Spouse, or Dependent Name _____

SSN (last 3 digits) XXX-XX-X _____

Date of Birth _____

Medicare Part B Enrollment Date _____

Return the signed Medicare Part B Premium Reimbursement Affidavit along with a copy of your Medicare Health Insurance Enrollment Card to the Trust Office. Please retain a copy of the completed, signed form for your records.

California Teachers Association
Employees' Health & Welfare Benefits
2250 S Rancho Road, Suite 295 ♦ Las Vegas NV 89102-4454 ♦ (888) 243-2325

MEDICARE PART B REIMBURSEMENT
DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize California Teachers Association Employees' Health & Welfare Benefits to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account listed below, in the financial institution shown below. I further authorize the financial institution named to credit and/or debit such account. I understand that this authorization remains in effect until the Trust Fund receives from me, in writing, notification to terminate the authorization in such a time and manner as to afford the Trust Fund and my financial institution a reasonable time to act on it.

Participant Information

Participant Name (please print) _____ XXX-XX-X _____ Social Security Number

Mailing Address _____ Email _____

City _____ State _____ ZIP - Z+4 _____ Telephone Number _____

Account Information

Account Number: _____ ☐ Checking ☐ Savings

Transit / ABA (Routing) Number _____ Name of Financial Institution _____

Financial Institution's Street Address:

_____

Participant Authorization

I certify that the above information is correct:

x _____ _____
Signature of Participant Date