Premium Adjustment Reimbursement Form

HOMECARE WORKER
Supplemental & Benefits Trusts

Last Name: _____ First Name: _____

Full Address: _____

SSN: _____ Date of Birth: _____

Phone Number: _____

Email Address: _____

"I certify that the information provided on this Premium Adjustment Reimbursement Form and on my enclosed IRS Forms is true, to the best of my knowledge and belief. I also certify that I have not already received any reimbursement or payment from any other source relating to the premium tax credit overpayment reflected on my enclosed IRS Forms."

Signature: _____ Date: _____

Please Mail or Fax this form and supporting documents (tax forms 1040, 1095 & 8962) to:

Mail: Oregon Homecare Workers Trust, PO Box 6, Mukilteo, WA 98275
Fax: Oregon Homecare Workers Trust, 1-866-459-4623
Email: OHCWT@bsitpa.com Subject: OHCWT
Phone: 844.507.7554 Option 3, then select Option 2