KAISER ALUMINUM SALARIED RETIREES VEBA PLAN
QUALIFIED BENEFIT REIMBURSEMENT REQUEST FORM
2014 PLAN YEAR

Delta Fund Administrators, LLC, Third Party Administrator, P.O. Box 2308, Stockton, CA 95201-2308
Telephone: Toll Free (888) 344-8322

Please read the following before completing this Qualified Benefit Reimbursement Request Form.

- **The Board of Trustees has declared a Qualified Benefit payable under the Plan of up to $2,800 per Family Unit for the Plan Year 2014. Please refer to the Plan's Summary Plan Description for an understanding of the Qualified Benefits that may be paid under the Plan and the terms used in this Qualified Benefit Reimbursement Request Form.**

- **Only health care premiums paid for coverage during 2014 under a Health Care Plan that provides medical, prescription drug, dental and/or vision care benefits are eligible for reimbursement as a Qualified Benefit for the 2014 Plan Year.**

- **The Qualified Benefit Reimbursement Request Form must be filed with the Third Party Administrator at the address indicated at the top of this Form on or before December 31, 2015. If a Qualified Benefit Reimbursement Request Form is not filed within this Reimbursement Request Period, then all rights to receive a Qualified Benefit for the 2014 Plan Year (or any portion thereof not already claimed) shall expire and be forfeit.**

Instructions

Medicare Part B Premiums – If you are requesting reimbursement of Medicare Part B Premiums, you must attach a copy of your Medicare Card showing that such coverage has been elected. Reimbursement will be made at the standard 2014 Medicare Part B premium rate of $104.90 per month based upon the total number of whole months that have elapsed prior to the receipt of your Qualified Benefit Reimbursement Request Form by the Third Party Administrator. If you are required to pay and are claiming reimbursement of Medicare Part B premiums in excess of the standard 2014 Medicare Part B premium rate, you must submit Proof of Payment of such excess premiums.

Medicare Part D Premiums – If you are requesting reimbursement of Medicare Part D Premiums, you must attach both Proof of Coverage under your Medicare Part D prescription drug policy or plan and Proof of Payment of such premiums.

Other Health Care Plan Premiums – If you are requesting reimbursement of premiums paid for coverage under another Health Care Plan (including coverage under a Medicare supplemental "Medigap" policy, such as A through N, a Medicare Select policy, or coverage under a "Medicare Advantage" or other HMO or PPO managed care or similar plan), you must attach both Proof of Coverage under your policy or plan and Proof of Payment of such premiums.

Proof of Coverage – A copy of the policy or contract, or a written certificate or other evidence of coverage if one is issued, is valid Proof of Coverage under a Health Care Plan, provided it clearly identifies an individual as a covered individual under that Health Care Plan.

Proof of Payment –

Health Care Premiums. A copy of an invoice and a copy of a cancelled check or signed payment receipt is valid Proof of Payment of health care premiums provided that the check was made payable to, or the payment receipt was received from, a Health Care Plan for coverage under that Health Care Plan. A copy of the relevant portion of a bank statement marked to show a premium payment under a Health Care Plan by electronic transfer of funds is valid Proof of Payment by that method or, if the bank statement is not clear, a copy of the premium statement, policy page or rider indicating the stated premium may be submitted.

Medicare Part D Premiums. If your Medicare Part D premiums are paid through deductions to Social Security benefits, a Benefit Verification Letter from the Social Security Administration during the year (setting forth 2014 year-to-date Social Security benefit payments and deductions) or a copy of a Social Security Benefit Statement Form SSA-1099 (to be issued in January 2015 for benefits received during 2014) is valid Proof of Payment of such premiums.

(Please complete this Qualified Benefit Reimbursement Request Form on the reverse side.)

Excess Medicare Part B Premiums. If you are required to pay and are claiming reimbursement of Medicare Part B premiums in excess of the standard 2014 Medicare Part B premium rate ($104.90/month), you must submit as Proof of Payment any one of the following: (i) a copy of the letter you received from the Social Security Administration informing you of the increased Medicare Part B premiums you are required to pay for 2014, or (ii) a Benefit Verification Letter from the Social Security Administration during the year (setting forth 2014 year-to-date Social Security benefit payments and deductions) or (iii) a copy of your Social Security Benefit Statement Form SSA-1099 (to be issued in January 2015 for benefits received during 2014).

Please complete the following:

Amount of Medicare Part B Premiums Claimed **$** _____

Amount of Medicare Part D Premiums Claimed **$** _____

Amount of Other Health Care Premiums Claimed **$** _____

Total **$** _____

Name of Retiree or Surviving Spouse: _____

Social Security No. of Retiree or Spouse: _ _ _____

Name of Designated Family Unit Representative: _____

Mailing Address (Street or P.O. Box): _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____ Email (if available): _____

Please attach all required Proofs of Coverage and Proofs of Payment to this Form.

Certification: By signing this Qualified Benefit Reimbursement Request Form, the Family Unit Representative hereby certifies: (a) that the information contained in and attached to this Qualified Benefit Reimbursement Request Form is complete and correct to the best of his or her knowledge and belief, and (b), to the extent that reimbursement of any Medicare Part B premiums is being claimed, that coverage under Medicare Part B remains in force and that all premiums for such coverage have been paid as of the date of this Qualified Reimbursement Request Form either directly or by deduction from Social Security benefits.

Certification of Surviving Spouse: By signing this Qualified Benefit Reimbursement Request Form, I hereby certify that my date of marriage to the Retiree was _____/_____/_____, and that I have not remarried. As a result of his/her death, I am the Family Unit Representative.

Signature of Family Unit Representative: _____

Date Signed (MM/DD/YYYY): / / _____