ROBERT JOHN...

ILWU-PMA Benefit Plans - 1188 Franklin Street
San Francisco, CA 94109 (415) 673-8500

MEDICARE PLAN REIMBURSEMENT RATE INCREASE

The monthly Medicare (Part B) premium rate commencing July 1, 1978 is $8.20 for each eligible Medicare enrollee. Reimbursement based on the new rate is included in this payment for all Medicare eligibles, and the amount is noted on each check stub as follows:

Medicare
$8.20

(1-person rate)

Medicare
$16.40

(2-person rate)

DISABLED PERSONS UNDER AGE 65

A disabled person under age 65 is entitled to Medicare coverage after the 24th month of his or her social security benefit entitlement date. A person under age 65 must notify the Benefit Plans office when he or she becomes eligible for Medicare. ILWU-PMA Welfare Plan health coverage is combined with Medicare when an eligible person is enrolled in Medicare. Therefore, if you have not reported your own or your dependent's entitlement to Medicare--do so now, as this will allow us to reimburse your Medicare premium.

ALL PENSIONERS/WIDOWS

The Benefit Plan office should be notified should any event listed below occur.

1. A change of marital status-
   - (a) Divorced or separated
   - (b) Married
   - (c) Widowed
2. A change of Medicare status-
   - (a) Loss of Part B coverage
   - (b) Medicare entitlement before age 65

For your information, ILWU locals keep a supply of record change forms for reporting such changes.

TJ/jc
7/1/78 - OPEU/29 F-3-b-149

F-3-b-150a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
06/19/78	07/19/78

ACCOUNT NUMBER: 00-47395-2

DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO.
M	2	1

LUEDELLA JOHNSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
01	30 90	01	72 90	50 00	164 23	00	359 90

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
	309 90	6 28				50 00	6 28
DP	72 90	7 07				122 90	7 07
						122 90	

ENDING BALANCE

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

F-3-b-150b

NUMBER

June 23 1978

11-3
1210

PAY TO THE ORDER OF Cash $309.90/100

Three hundred nine and ninety 90/100 DOLLARS

Bank of Montreal
(California)
SAN FRANCISCO, CALIFORNIA

LURDELLA JOHNSON

MEMO Cash

Lurdella Johnson

⑆1210⑈0003⑈ 00 47395 2⑈ ⑈0000030990⑈

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
SAN FRANCISCO, CALIF. 94104

DATE 19 78

LURDELLA JOHNSON
P.O. BOX 1156
SAN FRANCISCO, CALIF. 94115

	CASH		
CHECKS	Soc. Sec.	72	90
	TOTAL		
	LESS CASH RECEIVED		
TOTAL ITEMS	NET DEPOSIT	72	90

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

11-3 Data Processing Services 11-3

F-3-b-150c

⑆1210⑈0003⑈ 00 47395 2⑈ ⑈0000007290⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 04506

I ACKNOWLEDGE RECEIPT IN CASH OF THE FULL FACE AMOUNT OF THIS CHECK.

PAY ANY BANK P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3

PAY TO THE ORDER OF 11-3

Bank of Montreal
(California)

FOR DEPOSIT ONLY

CHECK CASHING AND
MONEY ORDER SERVICES
COMPANY
00-10362-4

0300 17167

PAY ANY BANK P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3 11-3

JUL -7 78

F-3-b-1519

8681

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance, Division of International Operations
Post Office Box 1756, Baltimore, Maryland 21203, U.S.A.

Date: 8/2/78

Claim Number: 438-64-3394 HA

DONALD JACKSON
% MISSION VILLAGE
PO BOX 893
GEORGETOWN GUYANA
SOUTH AMERICA 894

THE BENEFITS PAYABLE ON THIS SOCIAL SECURITY RECORD HAVE BEEN ADJUSTED.

AS YOU REQUESTED, YOUR MEDICAL INSURANCE PROTECTION HAS BEEN STOPPED EFFECTIVE THE LAST DAY OF 06/78. THIS NOTICE CONCERNS MEDICAL INSURANCE ONLY. IF YOU HAVE HOSPITAL INSURANCE, THAT COVERAGE WILL CONTINUE. MEDICAL INSURANCE PREMIUMS WILL NO LONGER BE DEDUCTED FROM YOUR SOCIAL SECURITY PAYMENTS.

YOUR NEXT PAYMENT WILL BE ADJUSTED FOR ANY MEDICAL INSURANCE PREMIUMS PREVIOUSLY PAID OR FOR ANY PREMIUMS NOW DUE.

IF YOU WANT INFORMATION ABOUT STARTING YOUR MEDICAL INSURANCE AGAIN, PLEASE GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE. THE PEOPLE THERE WILL BE GLAD TO ASSIST YOU AND ANSWER ANY QUESTIONS ABOUT THIS MATTER.

IF YOU DO NOT INTEND TO RETURN TO THE UNITED STATES, YOUR DECISION TO WITHDRAW FROM THE MEDICAL INSURANCE PROGRAM MAY BE WISE. HOWEVER, IF THERE IS A POSSIBILITY THAT YOU MAY RETURN TO THE UNITED STATES IN THE FUTURE, TO LIVE OR TO RECEIVE MEDICAL SERVICES, YOU MAY WISH TO CONSIDER CONTINUING YOUR MEDICAL INSURANCE PROTECTION. YOU SHOULD ALSO CONSIDER THE LIMITATIONS ON REENROLLMENT IN THE PROGRAM.

YOUR NEXT PAYMENT FOR $502.90 WILL INCLUDE BENEFITS DUE THROUGH 07/78. AFTER THAT, YOU WILL RECEIVE YOUR REGULAR MONTHLY CHECK FOR $494.70.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, PLEASE GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE OR WRITE TO US AT THE ABOVE ADDRESS.

I

(OVER)

Important: See other side for an explanation of your appeal rights and other information. ▶

If you believe this determination is not correct, you may request that your claim be reexamined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office. *Residents of the United States, Canada, and Mexico may call, write, or visit any social security office.* If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice. If additional evidence is available, you should submit it with your request.

1. Work Outside the U.S.

If you work or own a business outside the U.S.—and you're still under 72—you may not be eligible for social security benefit checks. It's in your best interest to report all employment even though you don't think your work or business will affect your social security checks. By employment, we mean you have a job—even a part-time job—or you are working for yourself as a farmer, writer, sales representative, artisan, etc. Any work as an apprentice must also be reported. If you own a business, you should notify us even if you do not work in the business or receive any income from it.

Send your notice to us by airmail. If your work is not covered by the United States social security program, the general rule is that you can't get a check for any month you've worked or owned a business on any part of 7 or more days while you're under 72. If you can't get a check, then neither can any of your dependents. If your work is covered by the United States social security program, the same annual retirement test will be applied as is applied to beneficiaries in the United States. If you want a fuller explanation, see the people at your nearest U.S. Foreign Service post.

We cannot explain in detail how your checks may be affected by your work. However, upon receipt of your work notice, we will send you a form to fill out. The information you submit on the form will help us decide whether your work or business will affect your checks. You will receive a decision in writing.

2. If You Are Enrolled For Medical Insurance Coverage This Information About Medical Insurance Premiums Applies to You

a. *If monthly social security benefits are being paid to you now—*

Your next payment will be adjusted for any premiums you now owe or excess premiums you have paid in advance. After that, 1 month's premium will be withheld from your benefit payment each month.

b. *If monthly social security benefits are not being paid to you now—*

You will be billed for the premiums to pay for your medical insurance. The first bill you receive will cover all premiums due at that time. Further bills will cover the premiums due in advance for a 3-month period.

Each bill will show the months covered and will be sent to you shortly before the payment is due.

c. *Medicare outside the U.S.*

Generally, no Medicare services are provided outside the U.S. The only exceptions are inpatient services provided in Canadian or Mexican hospitals, in limited situations involving emergencies occurring inside the U.S. or while traveling through Canada between Alaska and another State, or where the foreign hospital is nearer the beneficiariary's residence in the U.S. than the nearest U.S. hospital which can provide the care needed. There is a monthly premium charged for Supplementary Medical Insurance. Since you may cancel your Supplementary Medical Insurance at any time, and thereby *eliminate payment of the premium, you should consider* whether you wish to retain your Supplementary Medical Insurance.

You may cancel your medical insurance at any time. Residents of the United States, Canada, and Mexico may call, write, or visit any social security office for assistance. If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration, at the address shown on the reverse side of this notice. *The cancellation is not effective* until the third month after the month in which it is filed.

If you cancel your medical insurance, you can re-enroll at a later day, but only once. In that case, the premium is increased by ten percent for each full year that you could have been enrolled but were not.

3. Information About Overpayments

If you cannot afford to refund the full overpayment at one time or have your full payment withheld until the overpay*ment is recovered, get in touch with any social security office* to see about repayment by installments or having a smaller amount withheld from your social security payments over a longer period of time. If you live in the United States, Canada, or Mexico, you can get in touch with any social security office. If you live in the Philippines, you can contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice.

Any overpayment must be *withheld from benefits or paid* back unless both the following statements are true.

a. The overpayment wasn't your fault in any way and you accepted the payment(s) because you thought they were correctly paid to you, and

b. You couldn't meet your necessary living expenses if you had to pay back the overpayment or have it withheld from your social security payments, or if it would be unfair for some other reason.

If you believe you were without fault and that you should not have to repay the money, you should write to us at the address shown on the reverse side of this notice. We shall need a statement of your assets, monthly income, and expenses to help decide whether repayment would cause you financial hardship.

F-3-b-151b

A PERSON HAS ONLY TWO OPPORTUNITIES TO ENROLL IN THE MEDICAL INSURANCE PROGRAM. THIS ENDS YOUR FIRST ENROLLMENT. IF YOU WISH TO ENROLL AGAIN, YOU MUST SIGN UP DURING JANUARY, FEBRUARY, OR MARCH OF ANY YEAR. COVERAGE WOULD NOT BEGIN UNTIL THE FOLLOWING JULY AND YOUR PREMIUMS MAY BE HIGHER THAN THEY WOULD BE IF YOU HAD NOT WITHDRAWN FROM THE PROGRAM.

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

AUSTIN, TEXAS

Check No. 34,313,350
SYMBOL 2207

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER ... REQUIRE IDENTIFICATION

United States Treasury 15-51/000

PAY TO THE
ORDER OF MARY J RODGERS 03-766-771
719 PAGE ST 50 62 21
SAN FRANCISCO CA 94117 10 VA COMP

MONTH	DAY	YEAR
06	01	78

DOLLARS	CTS.
*****50	00

⑈22077⑈ ⑆0000⑉0051⑆ 343133505⑈

F-3-b-152

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

AUSTIN, TEXAS

Check No. 90,318,025
SYMBOL 2207

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER · · REQUIRE IDENTIFICATION

United States Treasury 15-51/000

PAY TO THE ORDER OF MARY J RODGERS 03-766-771
710 PAGE ST 2L 62 21
SAN FRANCISCO CA 94117 10 VA COMP

MONTH	DAY	YEAR
06	30	78

DOLLARS	CTS
$****50	00

⑈22077⑈ ⑆0000⑈0051⑆ 903180256⑈

F-3-b-153

F-3-b-154a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOIUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 224

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
05/19/78	06/19/78

ACCOUNT NUMBER: 00-47401-0

DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	01	19580	114410	125779	00	114410

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	19580	602				133990	602
						133990	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Bank of Montreal (California) F-3-b-154b

S.F
OFFICE

5-22-78
DATE

ADVICE OF MISPLACED CHECK

TO OUR DEPOSITOR: Odenia Roberson

ACCOUNT NUMBER 00-47401-0

ATTACHED IS THE MISPLACED CHECK (OR OTHER DEBIT ENTRY) THAT WAS PREVIOUSLY CHARGED TO YOUR ACCOUNT ON 5-19-78 IN THE AMOUNT OF $ $ 954.00

THIS ITEM WAS REPORTED TO YOU AT THE TIME YOU RECEIVED YOUR STATEMENT.
WE APPRECIATE YOUR PATIENCE IN THIS MATTER.

DATE OF THIS TRANSMITTAL _____

AUTHORIZED SIGNATURE

AC-80 (4/75)

TRANSMITTAL TO DEPOSITOR

F-3-b-154c

NUMBER

April 25 1978

11-3
1210

$ 254.00

PAY TO THE ORDER OF Cash

DOLLARS

Bank of Montreal (California)
883 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

ODENIA ROBERSON

Odenia Roberson

⑆1210⑈0003⑈ 00 47401 0⑈ ⑈0000025400⑈

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal (California)
883 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 6/2 1978

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

CASH	
CHECKS	Soc. Sec. 195 80
TOTAL	
LESS CASH RECEIVED	
NET DEPOSIT	195 80

[redacted]

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

11-3 Services 11-3

F-3-b-154d

⑆1210⑈0003⑈ 00 47401 0⑈ ⑈0000019580⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

Bank of Montreal (California)

DATE

OFFICE

ADVICE OF MISPLACED CHECK

ACCOUNT NUMBER

ATTACHED IS THE MISPLACED CHECK (OR OTHER DEBIT ENTRY) THAT WAS PREVIOUSLY CHARGED TO YOUR ACCOUNT IN THE AMOUNT OF $

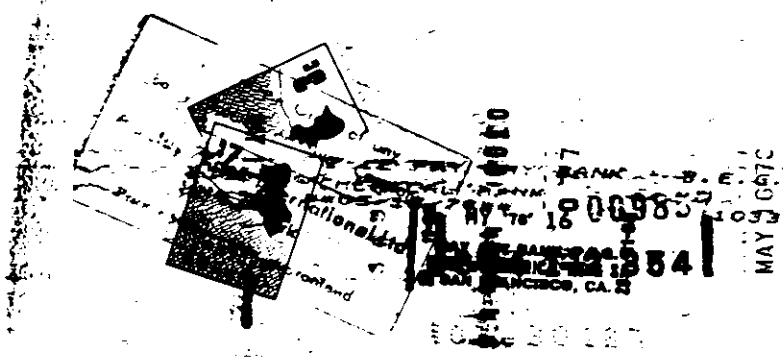
THIS ITEM WAS RECORDED TO YOU AT THE TIME YOU RECEIVED YOUR STATEMENT.

WE APPRECIATE YOUR PATIENCE IN THIS MATTER.

DATE OF THIS TRANSMITTAL

AUTHORIZED SIGNATURE

TRANSMITTAL TO DEPOSITOR



0300 65712

PAY ANY BANK P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3 11-3

JUN -2 78

F-3-b-155a

Bank of Montreal (California)

STATEMENT OF ACCOUNT

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
06/19/78	07/19/78
ACCOUNT NUMBER	
00-47401-0	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	01	270 70	133990	145720	00	133990

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	270 70	7 07				161060	7 07
						161060	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

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SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Bank of Montreal (California)

SF

Branch

We advise having credited your account with the amount(s) shown.

C/A 474010 Account 7-7 1978

Credit:

Odenia Robinson

P.O. Box 15156

S.F., Ca 94115

DD-2 12/72

Particulars

F-3-b-155b

Amount

Sac. Ser. $270.70

BANK OF MONTREAL (California)

JUL 7 1978

11-3 Bookkeeping Services 11-3

Teller

00 474010 00 00000270 70

0300 17137

PAY ANY BANK P.E.O.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA
11-3 11-3

JUL -7 70

F-3-b-156a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
07/19/78	08/18/78
ACCOUNT NUMBER	
00-47401-0	

DEPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

ODENIA ROBERSON
P.O. BOX 1515c
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	216.80	161.060	172.622	00	161.060

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	216.80	803				182.740	803
						182.740	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

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- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
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- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

[redacted]

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
[illegible] CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 8/3 1978

CASH		
CHECKS Soc. Sec.	216	80
TOTAL		
LESS CASH RECEIVED		
TOTAL ITEMS NET DEPOSIT	216	80

BANK OF MONTREAL (California)

[redacted]

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

11-3 Bookkeeping Services 11-3

F-3-b-156b

⑆1210⑈0003⑆ 00 47401 0⑈ ⑈0000021680⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

[redacted]

[redacted]

0300 57820

PAY ANY [illegible] P.E.G.
BK. C[illegible] [illegible]REAL
(CA[illegible]NIA)
SAN [illegible] [illegible]O CA.
11-3 11-3

AUG -3 78

F-3-b-157a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
08/18/78	09/19/78

ACCOUNT NUMBER: 00-47401-0

DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	21680	182740	192902	00	182740

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	21680	905				204420	905
						204420	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
[illegible] CALIFORNIA STREET
SAN FRANCISCO, CALIF. [illegible]

DATE 9/4 1978

CASH		
CHECKS	Automatic deposit	
TOTAL		
LESS CASH RECEIVED		
TOTAL ITEMS	NET DEPOSIT	216.80

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

F-3-b-157

⑆1210⑈0003⑆ 00 49401 0⑈ ⑈0000021680⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT.

0300 00933

PAY A[illegible] P.E.G.
BK. C[illegible] REAL
(C[illegible] A)
SAN [illegible] CA.
11-3 11-3

SEP -5 78

Bank of Montreal (California)

SF Branch

We advise having credited your account with the amount(s) shown.

C/A 474010 Account 7-7 1978

To

Odenia Roberson
P.O. Box 15156
S.F., Ca. 94115

DO-2 12/72

Particulars F-3-b-158 Amount

Soc. Sec. $270.70

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal (California) 333 California Street San Francisco, Calif. 94104

DATE 8/3 1978

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

CASH		
CHECKS	Soc. Sec.	216 80
TOTAL		
LESS CASH RECEIVED		
TOTAL ITEMS / NET DEPOSIT	216	80

[redacted]

11-3 / 1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

F-3-b-159

⑆1210⑈0003⑆ 00 47401 0⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT.

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal (California) 333 California Street San Francisco, Calif. 94104

DATE 9/4 1978

ODENIA ROBERSON
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

CASH		
CHECKS	Overpaid deposit	
TOTAL		
LESS CASH RECEIVED		
TOTAL ITEMS / NET DEPOSIT	216	80

[redacted]

11-3 / 1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

F-3-b-160

⑆1210⑈0003⑆ 00 47401 0⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT.

F-3-b-161

EMBASSY OF THE
UNITED STATES OF AMERICA
Georgetown, Guyana

August 17, 1978

Mrs. Willie B. Reed
Box 893
Georgetown, Guyana

Dear Mrs. Reed:

We refer to a request for services received from the office of the Social Security Administration in Baltimore, Maryland concerning an overpayment made to you in the sum of $112.40 and a penalty which was imposed because you did not file an annual report on time.

Their office has received your correspondence of April 25, 1978 and the penalty has been revoked. However, there is still an outstanding overpayment of $112.00 and if you request a waiver, please complete and return to this office the attached SSA-632. The overpayment may be recovered by withholding $10.00 a month, as requested in your letter or, if you wish partial withholding, a signed statement to this effect will be necessary.

Sincerely,

Douglas V. Ellice, Jr.
American Consul

Enclosure:
As stated above

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Notice of termination of medical insurance benefits

Date: 09/25/78

Claim No: 423-16-8734 A

WILLIE B REED
P O BOX 893
GEORGETOWN GUYANA 894

Date Your Medical Insurance Ends
SEP 30, 1978

As you requested, your medical insurance protection has been stopped. The date your coverage ended is shown above. This notice concerns your medical insurance only. If you have hospital insurance, that coverage will continue.

Medical insurance premiums will no longer be deducted from your social security checks. If any excess premiums have been withheld from your benefits, they will be refunded in a separate check.

Please write to the address shown above if you want information about starting your medical insurance again.

F-3-b-162

F-3-b-163a

423-16-7 34

NAME OF OVERPAID PERSON(S) | NAME OF INSURED INDIVIDUAL

Willie B. Reed | Same

Privacy Act Notice: If an overpayment has been made, the Social Security Administration (SSA) is required by law* to recover such amount unless recovery of the overpayment may be waived. Recovery of an overpayment may be waived only if you are not at fault in connection with the overpayment AND recovery would deprive you of income necessary to meet your ordinary living expenses or would be otherwise unfair. The information requested on this form is authorized by law and will enable SSA to determine whether recovery may be waived. If SSA determines that recovery may not be waived, the financial information on this form may be important in establishing the rate of recovery or the extent of the recovery efforts. Disclosure of information requested on this questionnaire is voluntary, but failure to provide the information requested may result in a denial of your request for waiver, and, if SSA is unable to recover the overpayment, it may be necessary to report the overpayment to the General Accounting Office for further collection effort.

The information you furnish on this form may be disclosed by SSA to another person or to another government agency for the following purposes:

1) to assist SSA in establishing the right of an individual to social security or black lung benefits and/or the amount thereof;
2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the programs administered by SSA; and
3) to comply with Federal laws requiring the exchange of information between SSA and another agency (such as the General Accounting Office).

* Sections 204, 1631(b), and 1870 of the Social Security Act, as amended (42 United States Code 404, 1383, and 1395gg) and section 413(b) of the Federal Coal Mine Health and Safety Act of 1969, as amended (30 United States Code 923(b)).

PART I - WITHOUT FAULT STATEMENT

(To be completed by all applicants for waiver)

1. Explain fully why you thought the incorrect payment was due you and why the overpayment was not your fault.

The income was below the maximum limit, and I had not worked the full year.

2. Did you report the change which affected your monthly payment? ☒ Yes ☐ No

IF "YES" WHEN DID YOU REPORT? (Give date) April 25, 1978

IF "NO" WHY DIDN'T YOU REPORT?

3. If you are overpaid because of your earnings, what did you do to limit your earnings?

Wil I did was stop working and I retired

Form SSA-632 (2-77) Previous editions of this form are obsolete

In October, 1976 when I first got work.

5. Do you NOW fully understand reporting responsibilities? ☒ Yes ☐ No
If "No," explain:

PART II - REPRESENTATIVE PAYMENT MADE

(To be completed ONLY by a representative payee)

6. Give the name and present address of the person for whom you received payment:

7. Were the incorrect payments used for this person? ☐ Yes ☐ No
Explain

PART III - POSSESSION OF OVERPAYMENT

(To be completed by all applicants for waiver)

8. Do you have any of the incorrectly paid checks or payments in your possession? ☐ Yes ☒ No
If "Yes," show the total amount ____ $ ____

THESE FUNDS SHOULD BE RETURNED TO SOCIAL SECURITY IMMEDIATELY.

9. Have you transferred by loan, gift, sale, etc. any property or cash since you were notified of the overpayment? ☐ Yes ☒ No
If "Yes," explain:

10. Have you been advised that you will receive an inheritance? ☐ Yes ☒ No
If "Yes," explain:

F-3-b-163b

[illegible] any income of you, [illegible] or any dependent [illegible] living in the household with you) from:	INCOME
Social Security benefits	$ 112.00
Supplemental Security Income payment	$ —
State or local welfare payment. Specify:	$ 0
Other benefits, such as Veterans Administration, civil service, unemployment, Black Lung, railroad, private pension, etc. Specify:	$ 0
Earnings (take-home wages and average net earnings from self-employment.) Specify: (gross $3400)	$ 2800.00 net
Other income, such as dividends, interest, rentals, roomers or boarders, etc. Specify:	$ none
TOTAL MONTHLY INCOME	$ 2800.00

12. Do you support, either fully or in part, anyone other than yourself? ☐ Yes ☒ No
If "Yes," give the following information about each person you support:

NAME	ADDRESS	AGE	RELATIONSHIP TO YOU (IF NONE, ENTER "NONE.")

13. LIST THE USUAL EXPENSES OF YOUR HOUSEHOLD ON A MONTHLY BASIS:	MONTHLY PAYMENT
Rent or mortgage, including property tax	$ 50.00
Food	$ 30.00
Clothing	$ 10.00
Utilities (electricity, gas, fuel, telephone, water)	$ 5.00
Miscellaneous household expenses (repairs, cleaning supplies, etc.)	$ 0
Insurance (life, automobile, medical, household, etc.)	$ 5.00
Medical and dental care (not covered by insurance)	$ 0
Automobile expenses (gas, oil, maintenance) or other transportation costs	$ 0
Personal items (barber, hairdresser, toilet articles)	$ 10.00
Other expenses (such as newspapers, etc.) Specify:	$ 2.00

Other debts being paid by monthly installments:

CREDITOR	AMOUNT OWED	MONTHLY PAYMENT
	$	$
	$	$
	$	$
	$	$
TOTAL MONTHLY EXPENSES		$

your spouse own a[illegible] valuable pro[illegible] estate? ☐ Yes ☐ No

If "Yes," specify and give current market value. If mortgage, show amount of mortgage.

(b) List the amount of any funds you have (*including those of your spouse, if you live with your spouse*): Cash on hand	$ 250.00
Checking account balance	$
Name and address of financial institution(s):	
Savings account balance	$
Name and address of financial institution(s):	
Current value of any stocks and bonds	$
Name of stocks and bonds you have:	
Value of other personal property and other funds (trust funds, etc.)	$ 250.00
Explain: furniture	
TOTAL	$ 250.00

REMARKS:

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law and/or State law. I affirm that all information I have given in this document is true.

SIGNATURE OF OVERPAID PERSON OR REPRESENTATIVE PAYEE

SIGNATURE (*First name, middle initial, last name*) (*Write in ink*)	DATE (*Month, day, year*)
SIGN HERE Willie B. Reed	TELEPHONE NUMBER None
MAILING ADDRESS (*Number and street, Apt. No., P.O. Box, or Rural Route*) Post Office Box 893	
CITY AND STATE Georgetown Guyana — ZIP CODE	ENTER NAME OF COUNTY (IF ANY) IN WHICH YOU NOW LIVE So America

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (*Number and street, City, State, and ZIP Code*)	ADDRESS (*Number and street, City, State, and ZIP Code*)

FORM SSA-632 PAGE 4

U.S. Government Printing Office 1977—[illegible]

F-3-b-164

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance, Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Willie B. Reed
P O Box 893
Georgetown
GUYANA

Date: July 25, 1978
Claim Number:
423-16-8734 A

We are sending a check for $ 112.00 within a few days, which is due for the reason(s) below:

- ☐ Payment of Supplemental Lump Sum
- ☐ Payment of underpayment due
- ☒ Payment of an amount previously due or withheld
- ☐ Amount due because of an increase in rate.
- ☐ Check(s) returned by the former payee is (are) now payable to you.
- ☐ Payment is in addition to your regular monthly benefit check.
- ☐ Refund of benefits withheld because of work.
- ☐ Refund of excess medical insurance premiums.

This check along with the check you may have recently received for $2.30 represent the complete amount which was previously withheld from your benefits.

If you have questions about your claim, you may get in touch with any social security office or write to us at the above address.

Important: See other side for an explanation of your appeal rights and other information. ▶

If you believe this determination is not correct, you may request that your claim be reexamined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office. Residents of the United States, Canada, and Mexico may call, write, or visit any social security office. If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice. If additional evidence is available, you should submit it with your request.

1. Work Outside the U.S.

If you work or own a business outside the U.S.—and you're still under 72—you may not be eligible for social security benefit checks. It's in your best interest to report all employment even though you don't think your work or business will affect your social security checks. By employment, we mean you have a job—even a part-time job—or you are working for yourself as a farmer, writer, sales representative, artisan, etc. Any work as an apprentice must also be reported. If you own a business, you should notify us even if you do not work in the business or receive any income from it.

Send your notice to us by airmail. If your work is not covered by the United States social security program, the general rule is that you can't get a check for any month you've worked or owned a business on any part of 7 or more days while you're under 72. If you can't get a check, then neither can any of your dependents. If your work is covered by the United States social security program, the same annual retirement test will be applied as is applied to beneficiaries in the United States. If you want a fuller explanation, see the people at your nearest U.S. Foreign Service post.

We cannot explain in detail how your checks may be affected by your work. However, upon receipt of your work notice, we will send you a form to fill out. The information you submit on the form will help us decide whether your work or business will affect your checks. You will receive a decision in writing.

2. If You Are Enrolled For Medical Insurance Coverage This Information About Medical Insurance Premiums Applies to You

a. *If monthly social security benefits are being paid to you now—*

Your next payment will be adjusted for any premiums you now owe or excess premiums you have paid in advance. After that, 1 month's premium will be withheld from your benefit payment each month.

b. *If monthly social security benefits are not being paid to you now—*

You will be billed for the premiums to pay for your medical insurance. The first bill you receive will cover all premiums due at that time. Further bills will cover the premiums due in advance for a 3-month period.

Each bill will show the months covered and will be sent to you shortly before the payment is due.

c. *Medicare outside the U.S.*

Generally, no Medicare services are provided outside the U.S. The only exceptions are inpatient services provided in Canadian or Mexican hospitals, in limited situations involving emergencies occurring inside the U.S. or while traveling through Canada between Alaska and another State, or where the foreign hospital is nearer the beneficiariary's residence in the U.S. than the nearest U.S. hospital which can provide the care needed. There is a monthly premium charged for Supplementary Medical Insurance. Since you may cancel your Supplementary Medical Insurance at any time, and thereby eliminate payment of the premium, you should consider whether you wish to retain your Supplementary Medical Insurance.

You may cancel your medical insurance at any time. Residents of the United States, Canada, and Mexico may call, write, or visit any social security office for assistance. If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration, at the address shown on the reverse side of this notice. The cancellation is not effective until the third month after the month in which it is filed.

If you cancel your medical insurance, you can re-enroll at a later day, but only once. In that case, the premium is increased by ten percent for each full year that you could have been enrolled but were not.

3. Information About Overpayments

If you cannot afford to refund the full overpayment at one time or have your full payment withheld until the overpayment is recovered, get in touch with any social security office to see about repayment by installments or having a smaller amount withheld from your social security payments over a longer period of time. If you live in the United States, Canada, or Mexico, you can get in touch with any social security office. If you live in the Philippines, you can contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice.

Any overpayment must be withheld from benefits or paid back unless both the following statements are true:

a. The overpayment wasn't your fault in any way and you accepted the payment(s) because you thought they were correctly paid to you, and

b. You couldn't meet your necessary living expenses if you had to pay back the overpayment or have it withheld from your social security payments, or if it would be unfair for some other reason.

If you believe you were without fault and that you should not have to repay the money, you should write to us at the address shown on the reverse side of this notice. We shall need a statement of your assets, monthly income, and expenses to help decide whether repayment would cause you financial hardship.

WESTERN FEDERAL SAVINGS & LOAN ASSOCIATION

UNITED CALIFORNIA BANK
1435 BURLINGAME AVE., BURLINGAME, CALIF

90-1371
1211

44462

600 SOUTH HILL STREET, LOS ANGELES, CALIFORNIA 90014
MAIN OFFICE

Stanfield
201-003359-2

WESTERN FEDERAL 1000 dols 00 cts

OCT 25 1979

$ **1,000.00**

PAY TO THE ORDER OF

Donna E. Stanfield

WESTERN FEDERAL SAVINGS

201-SAN BRUNO-201

⑈00044462⑈ ⑆1211⑉1371⑆ 627909043⑈11

F-3-b-165

F-3-b-1669

UNITED STATES
CIVIL SERVICE COMMISSION
WASHINGTON, D. C. 20415

POSTAGE AND FEES PAID
U.S. CIVIL SERVICE COMMISSION
FIRST CLASS

CSA0900295

CLEAVE L SWINNEY
PO BOX 893
GEORGETOWN GUYANA

BRI 48-402
March 1979

L

BRI 48-402
March 1979

U.S. Civil Service Commission, Bureau of Retirement, Insurance, and Occupational Health, Washington, D.C. 20415

WE HAVE YOUR CHANGE OF ADDRESS

Direct deposit—authorized receiving point. (If blank, annuity checks go to home address below.)

Home address:

Your claim number:

F-3-b-166b

If you changed your check mailing address, we will direct your next payment to that address unless the monthly disbursing schedule would delay delivery. In such case, the change will be made for the following check. If your home address has changed, please notify your old post office to forward your mail. Please Note: If you requested other service in your communication, you will receive a separate reply.

Use the back of this form to notify us of future home address change.

U.S. Civil Service Commission, BRIOH Retirement Address Unit, P. O. Box 586, Washington, D.C. 20044

ABOUT YOUR ADDRESS—Monthly annuity payments go to your home address **UNLESS** you have authorized direct deposit into your account in a financial organization. (See enclosed acknowledgement.)

Information about your annuity and related benefits **ALWAYS** is sent to your home address; use the back of our acknowledgement form to notify us promptly if it changes. (If you have authorized direct deposit, no change will be made in that arrangement unless you tell us to mail your payments to your home address.)

FOR YOUR PROTECTION—Change of address requests must be over the signature of the annuitant. Changes reported to us by telegram, telephone, or a third party cannot be honored. Be sure to notify your old post office of any home address change so they can forward your mail.

F-3-b-166c

MORE ABOUT DIRECT DEPOSIT—If your annuity check still goes to your home address—and you travel, move, or have other check delivery problems—you may prefer direct deposit. If so, complete Standard Form 1199A, Authorization for Deposit of Federal Recurring Payments, which you get at any participating bank, savings and loan association, or Federal or State chartered credit union.

To change direct deposit to another financial organization, complete a new Standard Form 1199A with the new organization. Your home address also appears on SF 1199A and, if changed, we update our records when this form is filed with us.

EXPLAIN TO YOUR FAMILY—By law, annuity payments are for the use of the annuitant. Death, incapacity, or any other event affecting annuity title must be reported to us immediately. This is especially important if you authorize direct deposit to a financial organization.

CHANGE OF ADDRESS—Mail to:
U.S. Civil Service Commission
BRIOH Retirement Address Unit
Post Office Box 686
Washington, D.C. 20044

DO NOT USE THIS FORM TO HAVE YOUR ANNUITY PAYMENTS SENT TO A FINANCIAL ORGANIZATION OR TO CHANGE TO ANOTHER FINANCIAL ORGANIZATION. Instead, you must use Standard Form 1199A, Authorization for Deposit of Federal Recurring Payments, which you get at any participating bank, savings and loan association, or Federal or State chartered credit union.

PRINT YOUR NAME *(First, Middle, Last)*	YOUR RETIREMENT CLAIM NUMBER *(Including prefix "CSA" or "CSF")*	YOUR DATE OF BIRTH

NEW HOME ADDRESS *(Please print)*	NUMBER AND STREET
	CITY, STATE, AND ZIP CODE

YOUR SIGNATURE *(Sign your name—do not print)*

If you have authorized direct deposit to your account in a financial organization, no change will be made in that arrangement unless you indicate that you now want your check to be mailed to your home address. If you do, write your initials in the block below.

(Initials) [ ] I now want my annuity check sent to my home address.

TO CHANGE YOUR HOME ADDRESS ON OUR RECORDS . . .

Complete the back of the enclosed acknowledgement and mail it to this special unit for address changes:

United States Civil Service Commission
BRIOH Retirement Address Unit
Post Office Box 686
Washington, D.C. 20044

OTHER CORRESPONDENCE TO THE CIVIL SERVICE COMMISSION . . .

For prompt service, please address other correspondence to: U.S. Civil Service Commission, Bureau of Retirement, Insurance, and Occupational Health, Washington, D.C. 20415.

Always include your civil service retirement claim number, including the prefix "CSA" or "CSF" so that we can identify your records.

See Other Side

Prudential The Prudential Insurance Company of America

F-3-b-167

Inter-Company Message and Reply

☐ Group Pension Office
Hanover Road
Florham Park, New Jersey 07932

TO ABRAHAM L. STATEN
P.O. BOX 893
GEORGETOWN, GUYANA
SOUTH AMERICA

☒ Group Pension Division
Terminal Box 2314
Los Angeles, California 90054

b6
b7c

Attention	GA Contract No.	Date
MR. STATEN; [redacted]	9032	3-16-78

Message

In your letter you inform our office that you have not received your November 1, and December 1, 1977 pension payments in the amount of $407.50 each. Please note that our records show that your November 1, 1977 through March 1, 1978 checks were mailed to your old address in San Francisco, CA and were not return by the post office. A stoppayment with the bank have been place, on these

Signature

Reply

Checks, if you have any of these checks in your possession please return them so they can be reissue to you

Sincerely,
Sheryl Killogg
Pension Administrator
Group Pension Dept

Signature

Date

Nov + Dec Received. Have not yet received Jan - Apr.

Printed in U.S.A.
GP2280 ED 3-74

ORIGINAL COPY

Prudential The Prudential Insurance Company of America F-3-b-168

Inter-Company Message and Reply

☐ Group Pension Office
Hanover Road
Florham Park, New Jersey 07932

☒ Group Pension Division
Terminal Box 2314
Los Angeles, California 90054

TO ABRAHAM L. STATEN
P.O. BOX 893
GEORGETOWN, GUYANA
SOUTH AMERICA

b6
b7C

Attention	GA Contract No.	Date
Mr. STATEN: [redacted]	9032	3-16-78

Message

In your letter you inform our office that you have not received your November 1, and December 1, 1977 pension payments in the amount of $407.50 each. Please note that our records shows that your November 1, 1977 through March 1, 1978 checks were mailed to your old address in San Francisco, CA and were not return by the post office. A stop payment with the bank have been place on these

Signature

Reply

checks, if you have any of these checks in your possession please return them so they can be reissue to you

Sincerely,
Sheryl Kellogg
Pension Administrator
Group Pension Dept

Signature Date

Printed in U.S.A.
GP2289-A ED 3-74

DUPLICATE COPY

place of birth?

F-3-b-169

The Prudential
Insurance Company
of America

Western Home Office
P. O. Box 2314, Terminal Annex
Los Angeles, California 90051

Prudential

b6
b7c

ABRAHAM L. STATEN
P.O. BOX 893
Georgetown, GUYANA
South America

Group Annuity Contract No. 9632
Certificate No. [redacted]

Dear Mr. Staten:

Before we begin mailing your checks outside of the United States, as requested, we must have the enclosed form completed.

Future annuity payments will be withheld by the Prudential until this form and the Internal Revenue Service Form 1001 (if necessary) are received. Please notify Prudential of any change in your address so that payments may be promptly mailed to you at your new address.

We have enclosed a self-addressed envelope for your convenience.

Sincerely,

Sheryl Kellogg
Pension Administrator
Group Pension Dept.

GWP 258-A 9-77
GP 2356-A 9-77

F-3-b-170

The Prudential
Insurance Company
of America

Western Home Office
P. O. Box 2314, Terminal Annex
Los Angeles, California 90051

Prudential

b6
b7C

ABRAHAM L. STATEN
P.O. BOX 893
GEORGETOWN, GUYANA
SOUTH AMERICA

Group Annuity Contract No. 9032
Certificate No. [redacted]

Dear

Before we begin mailing your checks outside of the United States, as requested, we must have the enclosed form completed.

Future annuity payments will be withheld by the Prudential until this form and the Internal Revenue Service Form 1001 (if necessary) are received. Please notify Prudential of any change in your address so that payments may be promptly mailed to you at your new address.

We have enclosed a self-addressed envelope for your convenience.

Sincerely,

Shyrel Kellogg

GMP 258-A 9-77
GP 2356-A 9-77

[redacted]

[redacted]

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Date 6/9/78

Alfred R. Stahl
c/o Mission Village
P.O. Box 893
Georgetown
GUYANA SA

Your Claim Number
310-03-8968 A

We are withholding your social security checks for 06/78 and later months because we have not received the supplemental application we sent you. The form must be completed and returned before we can determine whether to start your benefit payments again.

If you have questions about your claim, please write to us at the above address.

Enclosures:
Form SSA-21
Envelope

F-3-Q-171

Department of Health, Education, and Welfare
Social Security Administration

Form SSA-L442 (5-74)

25 W 2511170566

******THIRTY-NINE AND 00/100 DOLLARS ****39*00
****

OCT 01 1978
NOT VALID BEFORE

ALFRED R STAHL*******
P O BOX 141
REDWOOD VALLEY CA 95470

0090 32 310038968

⑈2511170566⑈ ⑆1220⑈0021⑆154400358⑈ 11

F-3-b-172

F-3-b-173a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOIUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 224

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
05/19/78	06/19/78
ACCOUNT NUMBER	
00-47400-2	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

ALFRED R. STAHL
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	29890	261380	278735	00	261380

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	29890	602				291270	602
						291270	

ENDING BALANCE

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
[illegible] CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 6/2 19 78

CASH		
CHECKS	Soc. Sec.	298 90
TOTAL		
LESS CASH RECEIVED		
NET DEPOSIT	298	90

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

F-3-b-173b

ALFRED R. STAHL
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

11-3 11-3

⑆1210⑈0003⑈ 00 47400 2⑈ ⑈0000029890⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 65714

PAY ANY BANK P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3 11-3

JUN -2 78

Social Security Benefit Information

F-3-b-174

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Date
August 21, 1978

Carol A Stahl For
Bonnie L Stahl
PO Box 893
Georgetown
GUYANA SA 894

Your Claim Number
310-03-8968 C1

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Enclosures:
Form SSA-609
Form SSA-1425F

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Carol A Stahl
PO Box 893
Georgetown
GUYANA SA 894

Date
August 21, 1978

Your Claim Number
310-03-8968 B2

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Your full monthly benefit amount of $157.80 is due effective August 1978 based on your statement that you are no longer working. Please complete the enclosed form SSA 777 and return if to us as soon as possible in the envelope provided.

F-3-b-175

Enclosures:
Form SSA-609
Form SSA-1425F SSA-777

PURCHASE ORDER

PURCHASE ORDER NO. 7415

Date of P. O. 10-12-78

REQUISITION 07956

Date of Req. 10/11/78

UKIAH UNIFIED SCHOOL DISTRICT

ADMINISTRATIVE OFFICES:
~~P. O. Box 767~~ 445 S. DORA ST
~~School and Henry Streets~~
Ukiah, California 95482
Phone: 707-462-8633

SCHOOL DISTRICTS ARE NOT SUBJECT TO FEDERAL MANUFACTURER'S EXCISE TAX (Section 4224 Internal Revenue Code)

PLEASE SHOW SEPARATE DEDUCTIONS OF THIS TAX ON INVOICES.

YOUR INVOICE AND SHIPPING TAG MUST SHOW THIS ORDER NUMBER.

INVOICES MUST BE SUBMITTED IN TRIPLICATE TO INSURE PROMPT PAYMENT.

PREPAY ALL DELIVERIES

PURCHASE FROM

Carol Stahl
P.O. Box 141
Redwood Valley, Cal. 95470

Ship to..... SCHOOL

QUANTITY	UNIT	ITEM	PRICE	UNIT	AMOUNT
		Refund Blue Cross deduction for Sept. billing			21.27
		F-3-b-176			

MDSE. TOTAL .....

SALES TAX .....

TOTAL .....

Budget Classification 10-01-5900-795

(One classification per requisition)

REQUISITIONED By.....

AUTHORIZED By..... Principal

NOT VALID UNLESS SIGNED

Signed W. Om
Administration-Business Services

FOR SCHOOL PERSONNEL ONLY:
Submit the completed original, second and third copies to the Central Administration Office.
Fourth copy is retained by person or department initiating the requisition.

Received by ..... Signature

UKIAH UNIFIED

501932

REFERENCE	AMOUNT	REFERENCE	AMOUNT	REFERENCE	AMOUNT
F-3-b-177	21.27	Carol Stahl			

NOT NEGOTIABLE

TOTAL 21.27

BANK OF AMERICA

The Timesaver Statement

If you have any questions about this statement, please call us or bring this copy to your Bank of America branch.

F-3-b-178

EAST BAKERSFIELD OFFICE
P.O. Box 3009
BAKERSFIELD, CALIFORNIA 93305

PERIOD ENDING
FEB 03, 1978

BRANCH PHONE NO.
805-395-2382

13 DOROTHY SIMPSON
824 7TH ST
BAKERSFIELD CA 93304

0419-PS13

AT BANK OF AMERICA WE HAVE SIX DIFFERENT CHECKING PLANS TO CHOOSE FROM. THE CHOICE IS YOURS.

SUMMARY OF BANKING SERVICES (BALANCES SHOWN ARE AS OF STATEMENT DATE)

TYPE OF SERVICE	ACCOUNT NO.	CHECKS DEBITS NO.	CHECKS DEBITS AMOUNT	DEPOSITS NO.	DEPOSITS AMOUNT	NEW BALANCE
CHECKING	0419-9-04821	0	00	0	00	113962

CHECKING ACCOUNT ACTIVITY (USE REVERSE SIDE FOR RECONCILING TO YOUR RECORDS)

CHECKS AND OTHER DEBITS						DEPOSITS	
CHECK NO	DATE PAID	AMOUNT	CHECK NO.	DATE PAID	AMOUNT	DATE	AMOUNT

PREVIOUS BALANCE	AMOUNT OF ENTRIES YOU AUTHORIZED DEBITS	CREDITS	MINIMUM AVERAGE	ENCLOSURES
$1,139.62			$1139.00AV	0

Key to Symbols: * Gap in Check Sequence
** Includes Interest Payment Last Period
A Automatic Deposit
MN or AV Minimum or Average Balance used for Service Charge Calculation.
B BankAmericard® Instant Cash
R Reversing Entry
M Miscellaneous
OD Overdrawn

BDR-1 10-76 (REV.)

F-3-b-179

SAVINGS BANK OF MENDOCINO COUNTY
Ukiah, CALIFORNIA

Incoming Collection Letter

No. 32332

Date 8/18/78

Maker: Mrs. C. L. Swinney	Payer: 90-406
Description: correspondence to close checking 01-068884	
rs. C. L. Swinney (Hill Top Haven)	
Instructions	

Your No.	
Your Date	
Protest	Yes ☐ No ☒
Due Date	sight
Amount	bal 4214.01
Interest	
Total	4214.01
Less Exchange	
Enclosed Draft No. For	
We credit your A/C	
Reason For Non-Payment	

PAID

AUG 18 1978

Savings Bank of Men
UKIAH, CA

Mrs. C. L. Swinney
P. O. Box 893
Georgetown Guyana
South America

3CL-1

THIS IS TO ADVISE YOU THAT WE HAVE THIS DAY
CHARGED YOUR ACCOUNT AS FOLLOWS:

DATE: 8/18/78 ACCOUNT NUMBER: 01 068884 4

DESCRIPTION	NUMBER	INTEREST	PRINCIPAL	BALANCE	AMOUNT
Per correspondance close					
checking by collection					
				TOTAL	4214.01

MAIL TO Hill Top Haven

SAVINGS BANK OF MENDOCINO COUNTY

APPROVED BY

F-3-b-180

UNITED CALIFORNIA BANK
TRUST SERVICES

No. 82355869

DATE	TRUST NUMBER	ORIG	TRUST NAME
070178	410186019		WESTERN BANCORPORATION SUBFUND A

DESCRIPTION	CODE	AMOUNT	SECURITY NUMBER	NUMBER SHARES
WILLIE D. SNEED				
MONTHLY RETIREMENT BENEFIT		11821		
MEDICAL-DENTAL PLAN CONTRIBUTION		1250-		
F-3-b-181				
82355869		8103.71		

UNITED CALIFORNIA BANK
TRUST SERVICES

No. 82411945

DATE	TRUST NUMBER	ORIG	TRUST NAME
110178	410186019		WESTERN BANCORPORATION SUBFUND A

DESCRIPTION	CODE	AMOUNT	SECURITY NUMBER	NUMBER SHARES
WILLIE D. SNEED				
MONTHLY RETIREMENT BENEFIT		11621		
MEDICAL-DENTAL PLAN CONTRIBUTION		1250-		
F-3-b-182				
82411945		$103.71		

UNITED CALIFORNIA BANK
TRUST SERVICES

No. 82452673

DATE	TRUST NUMBER	ORIG	TRUST NAME
110178	410186019		WESTERN BANCORPORATION SUBFUND A

DESCRIPTION	CODE	AMOUNT	SECURITY NUMBER	NUMBER SHARES
WILLIE D. SNEED				
MONTHLY RETIREMENT BENEFIT		11621		
MEDICAL-DENTAL PLAN CONTRIBUTION		1250-		
F-3-b-183				
82452673		$103.71		

[redacted]

CONTROL 73070329071 PLAN 11 939 CLAIM 16808 DRAFT 2141523
EMPLOYER WESTERN BANCORPORATION SUB-GROUP 3-39 UCB
EMPLOYEE W D SNEED DEPENDENT DATE 11/04/77 11223 09

DESCRIPTION OF SERVICES		NO. DAYS CALLS	DATES OF SERVICE	AMOUNT CHARGED	AMOUNT COVERED		REMARKS
PROVIDERS	TYPE				MAJ. MED.	BASIC	
MENDOCINO COM HOSP	HL CUT-PAT		09-14-7	33.25	33.25		
	X-RAY-LAB			12.00	12.00		
				45.25	45.25		

F-3-b-184

NOTE - OUR DRAFTS ISSUED
36.20 TO W D SNEED

SUB TOTAL		45.25	0.00
45.25 @ 80%		36.20	
AMOUNT OF SETTLEMENT			36.20

MAJOR MEDICAL BENEFITS
PAID THIS TRANSACTION 36.20
PAID TO-DATE 657.32

MM CASH DEDUCTIBLE RECORD
APPLIED THIS TRANSACTION 0.00
DEDUCTIBLE REMAINING 0.00

W D SNEED
1551 ROAD D
REDWOOD VALLEY CA

L35G SAVE FOR TAX RECORDS

WESTERN BANCORPORATION

F-3-b-185

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Mid-America Program Service Center, Kansas City, Missouri 64106

Date:
08/01/78

Novella Sneed
c/o Mission Village
Box 893
Georgetown, Guyana So. America

Claim Number:
455-16-0848A

Your request that your social security benefit checks be mailed to the above address while you are outside of the United States has been received.

If you are under age 72 and do any work or engage in any business while outside of the United States, you may not be eligible to a benefit payment for any calendar month during which you work on any part of 7 or more days. This is true, regardless of how little you earn from such work, or how few hours you spend working during those 7 days.

If your social security checks are being sent to a United States bank for deposit to your account while you are outside the United States, you must notify the Social Security Administration when the need for this arrangement no longer is necessary.

We are enclosing a booklet which give information about work and other matters which affect your right to receive social security payments while you are outsdie the United States. We have also enclosed a form SSA-1425(F) which can be used to report the events described in the booklet.

Please complete and return the enclosed form SSA-21.

Enclosures
Form SSA-609

Form SSA-21

F-3-b-186

Supplemental Security Income
Notice of Change

950

From: Department of Health, Education, and Welfare
Social Security Administration

Date: 08-23-78

Social Security Number:
455-16-0848 AI

*NOVELLA SNEED
1029 GEARY #51
SAN FRANCISCO CA 94109

YOUR CHECK WILL STOP IN SEPTEMBER 1978.

YOU CANNOT GET SUPPLEMENTAL SECURITY INCOME CHECKS IF YOU ARE OUTSIDE THE UNITED STATES FOR A WHOLE MONTH. SINCE YOU ARE NOW OUTSIDE THE UNITED STATES, WE PLAN TO STOP YOUR CHECKS AS SHOWN ABOVE.

FOR INFORMATION ABOUT ANY CHANGE IN YOUR MEDICAID ELIGIBILITY CAUSED BY THIS ACTION YOU SHOULD GET IN TOUCH WITH YOUR COUNTY WELFARE DEPARTMENT.

Important: See other side for an explanation of your appeal rights and other information. ▶

Form SSA-8151 (12-76)

F-3-b-187a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOIUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 224

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
05/19/78	06/19/78
ACCOUNT NUMBER	
00-47348-0	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

NOVELLA SNEED
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	9580	19160	24722	00	19160

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	9580	6/02				28740	6/02
						28740	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc Standby Credit
SD Misc Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
SAN FRANCISCO, CALIF. 94104

DATE 5/4 1978

CASH		
CHECKS	Sec Sec	95 80
TOTAL		
LESS CASH RECEIVED		
NET DEPOSIT		95 80

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

NORELLA SNEED
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

F-3-6-187

⑆1210⑈0003⑆ 00 47348 0⑈

⑈0000009580⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 22481

PAY ANY BANK P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3 11-3

MAY -4 78

F-3-b-188a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOIUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 224

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
05/19/78	06/19/78
ACCOUNT NUMBER	
00-47403-7	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO.
M	1	1

BERTHA SMITH
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	01	19630	117780	129178	00	117780

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	19630	602				137410	602
						137410	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
333 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 6/2 1978

F-3-D-188

BERTHA SMITH
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

CASH			
CHECKS	Soc. Sec.	196	30
TOTAL			
LESS CASH RECEIVED			
NET DEPOSIT		196	30

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

11-3 Services 11-3

⑆1210⑈0003⑆ 00 47403 7⑈ ⑈0000019630⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 65709

PAY ANY BANK, P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3 11-3

JUN -2 78

Social Security Benefit Information

F-3-k-189

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

IRI-71734:PE

Virginia V. Taylor
PO Box 893
Georgetown
GUYANA

Date
September 12, 1978

Your Claim Number
205-12-2261 A

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Shortly you will receive a check representing payment due you for August 1977 through August 1978.

Enclosures:
Form SSA-609
Form SSA-1425F

464-18-4492 A 0 00 02/79

F-3-b-190

Form Approved.
Budget Bureau No. 72-6510

DO NOT RETURN THIS CARD UNLESS YOU PLAN TO COME TO THE UNITED STATES TO LIVE OR TO RECEIVE MEDICAL SERVICES.

ERNEST THOMAS
PO BX 893
GEORGETOWN GUYANA
SOUTH AMERICA 894

I understand that the Medical Insurance Program does not provide payment for services furnished outside the U.S.

Please send me further information about the program and an application which I may use if I decide to take this insurance.

SIGNATURE

PRYOR 6-04054

DHEW — SOCIAL SECURITY ADMINISTRATION

Form SSA 1739
(4-70)

F-3-b-191

18	F N 1525 41 35	0	2	39.50	7	5 18 78	43	0	3604744

THE VETERANS ADMINISTRATION WISHES TO MAKE SURE THAT YOU AS THE BENEFICIARY OF A GOVERNMENT LIFE INSURANCE POLICY, ARE RECEIVING YOUR MONTHLY CHECK(S). IF YOU ARE RECEIVING YOUR CHECK(S), PLEASE SIGN BELOW IN THE SAME MANNER YOU ENDORSE YOUR INSURANCE CHECK(S). ALSO, PLEASE INCLUDE YOUR DATE OF BIRTH AND RETURN THIS CARD IN THE ENCLOSED ENVELOPE WHICH NEEDS NO POSTAGE.

SIGNATURE (DO NOT TYPE OR PRINT): Bernice Thomas

DATE OF BIRTH: Jan 7, 1910

BERNICE THOMAS
1615 SUTTER #101
SAN FRANCISCO CA 94109

2ND REQUEST

FUTURE CHECKS MAY BE DELAYED IF YOU DO NOT PROMPTLY REPLY.

SEE REVERSE SIDE IF YOU SIGN WITH AN "X" MARK.

PLEASE INDICATE ANY CHANGE OF ADDRESS.

BENEFICIARY SIGNATURE CARD

VETERANS ADMINISTRATION

Social Security Benefit Information F-3-b-A2

From: Bureau of Retirement and Survivors Insurance, Division of International Operations
Post Office Box 1756, Baltimore, Maryland 21203 U.S.A.

Date
SEP 9 1978

Your Claim Number
570-18-9112 A

BERNELL M TARDY
BX 893
GEORGETOWN
GUYANA SO AMERICA 894

Reason for action
RETURNED CHECK

Type of action
REPAYMENT

☐ As a result of the action being taken, benefit payments have been refigured as shown below. The amount shown in column 4, represents all benefits due on this claim through the month shown in column 5. You will then receive the amount shown in column 3 regularly each month.

☐ Benefit payments have been discontinued with the month shown in column 2 for the reason shown above.

☐ We have determined that you are entitled to the benefits shown below.

☐ As shown below, the next payment will be sent to you shortly. You will then receive the amount shown in column 3 regularly each month.

1. Additional payment information	2. Effective month	3. Regular monthly payment	4. Net amount of next payment	5. Next payment will pay amt. due you through month of
THIS REPRESENTS BENEFITS DUE FOR JULY		155.60	155.60	8/78

If you believe that this determination is not correct, you may request that your case be re-examined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. Your social security office will be glad to assist you in making this request. If additional evidence is available you should submit it with your request.

If you have any questions about your claim, you should get in touch with any social security office. Most questions can be handled by telephone or mail. If you visit the office, however, please take this notice with you.

Note to Terminated Beneficiary:

Earnings for the entire year both before and after your benefits were stopped must be considered in determining whether you earned more than the allowable yearly limit as shown in Item 1 on the back of this notice. Also, see Item 2 for the annual reporting requirement.

Important: See other side for an explanation of your appeal rights and other information.

If you believe this determination is not correct, you may request that your claim be reexamined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office. If additional evidence is available, you should submit it with your request.

The information in items 1 and 2 below apply to all beneficiaries who are not disabled, including those receiving benefits as dependents of a disabled wage earner. Items 3 and 4 may apply to any beneficiary. Item 5 applies only to persons receiving benefits based on their own disability.

1. How Your Work and Earnings Affect Your Benefits

The recent social security amendments made two changes in the way that work affects your benefits. There are now two exempt amounts, one for people under 65 and a higher amount for people 65 or older. The second change in the law states that regardless of total yearly earnings, benefits may be paid for *nonwork* months under the monthly earnings test for only one year. (See item 1c below.) After benefits have been paid on this basis, future year's benefits are payable based solely on your total earnings for the year.

a. *If you are under age 65* and earn $3,240 (exempt amount) or less in a taxable year ending after December 1977, nothing will be withheld from your benefits.

b. *If you attain age 65 by the end of 1978 and you earn $4,000 (exempt amount) or less in a taxable year ending after December 1977, nothing will be withheld from your benefits.*

If you earn over the exempt amount in a year $1 will be withheld from your benefits for each $2 of earnings above $3,240 (under age 65) or $4,000 (over age 65). You will never have more than $1 in benefits withheld for each $2 of earnings above the exempt amount.

c. Effective with 1978, regardless of total earnings, benefits may be payable for any *nonwork* month; that is, a month in which you neither earn wages of more than $270 (under age 65) or $334 (over age 65) nor perform substantial services in self-employment. However, once the nonwork month(s) provision is used in a year, it is no longer applicable to any subsequent year. In subsequent years only the yearly earnings limitation test will apply.

Benefits are also payable for all months in which you are age 72 or older, regardless of the amount of your earnings in or after the month you reach 72. If you are self-employed only part of your total earnings have to be counted, for example, if you become age 72 in April, we count 3/12 of your total earnings, if you become 72 in May, we count 4/12 of your total earnings, and so on.

2. Report Any Significant Change in Your Work and Earnings to Any Social Security Office

Examples of important changes are:

a. If you go to work while under age 72 and expect to earn over the exempt amounts.

b. If you have previously reported that you expect to earn over the exempt amounts from work, but

(1) You stop work, or

(2) You do not earn over $270 (under age 65) or $334 (over age 65) for any month and you do not perform substantial services in self-employment, or

(3) You expect to earn substantially more or less in the year than you previously told us.

Prompt reports enable us to make adjustments to your benefit payments when you have income from work. Delayed reports make it necessary for us to withhold benefits during periods when you may not have income from work.

Even when benefits are terminated during the year, you must file an annual report if you earn over the exempt amounts. In this report include your earnings for the entire year both before and after your benefits were terminated.

Any difference between the amount of benefits withheld based on your estimate of earnings and the amount that must be withheld on the basis of your actual earnings will be adjusted after the close of the year when you file your next annual report.

3. If You Are Enrolled For Medical Insurance Coverage, This Information About Medical Insurance Premiums Applies to You

a. *If monthly social security benefits are being paid to you now—*
Your next payment will be adjusted for any premiums you now owe or excess premiums you have paid in advance. After that, 1 month's premium will be withheld from your benefit payment each month.

b. *If monthly social security benefits are not being paid to you now—*
You will be billed for the premiums to pay for your medical insurance. The first bill you receive will cover all premiums due at that time. Future bills will cover the premiums due in advance for a 3-month period.

Each bill will show the months covered and will be sent to you shortly before the payment is due.

4. Information About Overpayments

If you cannot afford to refund the full overpayment at one time or have your full payment withheld until the overpayment is recovered, get in touch with any social security office to see about repayment by installments or having a smaller amount withheld from your social security payments over a longer period of time.

Any overpayment must be withheld from benefits or paid back unless both the following statements are true:

a. The overpayment wasn't your fault in any way and you accepted the payment(s) because you thought they were correctly paid to you and

b. You couldn't meet your necessary living expenses if you had to pay back the overpayment or have it withheld from your social security payments, or if it would be unfair for some other reason.

If you believe you were without fault and that you should not have to repay the money, you should call, write, or visit any social security office to discuss the matter. The people there may ask you about your assets, monthly income, and expenses to help decide whether repayment would cause you financial hardship.

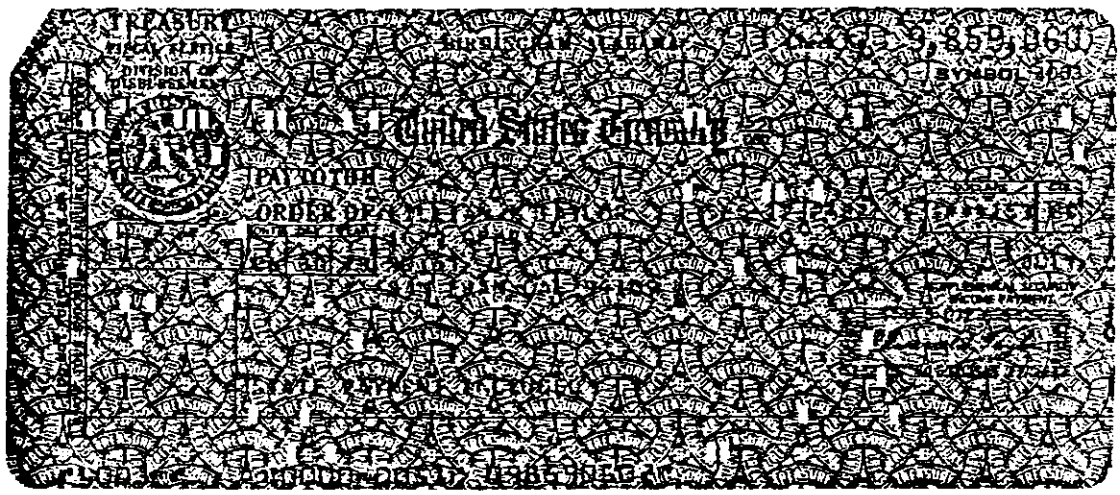
5. Special Reporting Events Needed Only From People Receiving Benefits Because of Their Disability

a. Your medical condition improves.

b. You return to work (regardless of how much you earn) or your work status changes (if you are working now.)

c. You begin receiving workmen's compensation benefits, the amount you are already receiving changes, or you receive a lump sum payment.

** The "Rights and Responsibilities Booklet" you received with your award certificate contains additional information concerning events you need to report.



F-3-b-193

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Chec : No. 81,738,598
SYMBOL 3127

United States Treasury 15-51/000

PAY TO THE ORDER OF LILLIAN M TAYLOR [redacted]
1029 GEARY
APT 51
SAN FRANCISCO CA 94109

MONTH	DA	YEAR
07	03	78

98 A 5

DOLLARS	CTS.
$***188	20

SOC SEC FOR JUN

D12
Clarence S. Taylor
REGIONAL DISBURSING OFFICER

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

⑈31273⑈ ⑆0000-0051⑆ 817385987⑈

b6
b7c

F-3-h-194

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Check No. £2,994,342
SYMBOL 3127

United States Treasury 15-51/000

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER... REQUIRE IDENTIFICATION

PAY TO THE ORDER OF

MONTH	DAY	YR
07	14	79

LILLIAN TAYLOR
1029 GEARY ST 51
SAN FRANCISCO CA 94100 [redacted]

DOLLARS	CTS.
$***119	78

42 TAX REF
RESNO 94

12/77

013
Clarence S. Taylor
REGIONAL DISBURSING OFFICER

b6
b7c

⑈31273⑈ ⑆0000⑉0051⑆ 829943422⑈

F-3-h-195

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Chec. No. 30,352,647
SYMBOL 3127

United States Treasury 15-51/000

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER ... REQUIRE IDENTIFICATION

PAY TO THE ORDER OF LILLIAN M TAYLOR
1029 GEARY
APT 51
SAN FRANCISCO CA 94109

[redacted] 47 A 5

DOLLARS	CTS.
$***188	20

SOC SEC FOR JUL

MONTH	DAY	YEAR
08	03	71

012
Clarence S. Taylor

⑈31273⑈ ⑆0000-0051⑆ 303526476⑈

F-3-b-196

66
67c

mailed 6/27/78
to
303 Golden Gate
SF 94102

F-3-b-197a

sent again 8/21/78

Memorandum or special commentary:

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. R0506

SUPPLEMENT TO CLAIM OF PERSON OUTSIDE THE UNITED STATES

(To be completed by or on behalf of person who is, was, or will be outside the U.S.)

For social security purposes a person is outside the United States if he is physically outside the 50 States, the District of Columbia, Puerto Rico, Virgin Islands, Guam, and American Samoa.

1. NAME OF WORKER ON WHOSE EARNINGS THIS CLAIM IS BASED: Lillian Taylor
   WORKER'S SOCIAL SECURITY NUMBER: [redacted]

2. PRINT YOUR NAME *(If you are filing application on behalf of an incompetent adult, enter his or her name in this space and answer all subsequent questions on this questionnaire FOR him.)* Lillian Taylor
   YOUR U.S. SOCIAL SECURITY NUMBER: [redacted]

b6
b7c

CITIZENSHIP

3. (a) At the time of your birth, of what country (or countries) were you a citizen? NAME OF COUNTRY (or countries): U.S.

(b) Have you ever become a citizen of any country other than the country or countries shown in (a) above? ☐ Yes ☒ No
If "Yes," give the name of the country and explain how and when citizenship was acquired.

(c) Of what country (or countries) are you now a citizen? → NAME OF COUNTRY (or countries): U.S.

(d) Do you have a valid passport? ☒ Yes ☐ No
If "Yes," give the following information:

DATE ISSUED	PASSPORT NO.	NAME OF GOVERNMENT THAT ISSUED PASSPORT
7-22-76	[redacted]	U.S.

IF YOU ARE A U.S. CITIZEN, answer (e) and (f) below. If You are not a U.S. citizen, go on to question 4.

(e) After becoming a U.S. citizen, have you ever been employed by a foreign government either in a civilian or military capacity? ☐ Yes ☒ No
If "Yes," explain when and where.

(f) After becoming a U.S. citizen have you ever been convicted of any crime against the U.S.? ☐ Yes ☒ No
If "Yes," explain what crime(s), when, and where.

PHYSICAL PRESENCE IN THE U.S.

4. (a) Have you ever been physically present in the U.S. at any time? ☒ Yes ☐ No

(b) Are you now physically present in the U.S.? ☒ Yes ☐ No

If "Yes," enter the date you plan to leave the U.S. → MONTH, DAY, YEAR: 6-22-78

If "No," enter the date you left the U.S. → MONTH, DAY, YEAR:

(c) When do you plan to return to the U.S.? → MONTH, DAY, YEAR:

(d) Did you enter or leave the U.S. at any time during the past 24 months? ☐ Yes ☒ No
If "Yes," give the following information concerning each of your arrivals and departures.

DATE OF ARRIVAL (Month, day, year)	DATE OF DEPARTURE (Month, day, year)	ADDRESSES OF PLACES YOU LIVED OR VISITED IN THE U.S.
		F-3-b-197b

FORM SSA-21 (5-73)

(Over)

EMPLOYMENT – SELF-EMPLOYMENT

A person is employed if he performs services for someone else and receives cash payment or other compensation for these services. This includes any part-time work or summer work by a child, or work by a child as an apprentice.

A person is self-employed if he has a business either by himself or with one or more partners. Some examples of self-employment are raising fruit, crops or livestock for sale, taking in sewing or laundry, providing services as a tutor, lawyer, or physician, etc. The amount of earnings (or loss) has no effect on whether the person is considered self-employed.

5. (a) Have you been employed or have you engaged in self-employment outside the U.S. during any of the past 24 months including the present month? ☐ Yes ☒ No

(b) If you are still in the U.S. will you engage in employment or self-employment outside the U.S.? ☐ Yes ☒ No

Give the following information about your employment or self-employment outside the U.S.

NAME AND ADDRESS OF EMPLOYER (If self employed, show "self" and name and address of your trade or business.)	TYPE OF BUSINESS	EMPLOYMENT OR SELF-EMPLOYMENT	
		DATE BEGAN OR WILL BEGIN	DATE ENDED (If not ended, leave blank)

CHANGES TO BE REPORTED PROMPTLY TO THE SOCIAL SECURITY ADMINISTRATION

Notify the Social Security Administration promptly if, while outside the U.S.:

(1) you become employed or self-employed while under age 72

(2) there is any change in your citizenship

(3) you go into a different country for more than 1 month.

6. (a) Do you agree to notify the Social Security Administration promptly when any of the above events occur? ☒ Yes ☐ No

FAILURE TO REPORT EMPLOYMENT OR SELF-EMPLOYMENT PROMPTLY AS AGREED MAY RESULT IN THE LOSS OF MONTHLY BENEFITS

(b) Do you also agree to return promptly any check for benefits received by you if you are not entitled to it? ☒ Yes ☐ No

MAILING ADDRESS

All social security checks are sent to the beneficiary's place of residence unless there is a valid reason for sending checks in care of another person or to another address.

7. (a) Give the complete address of residence abroad. (The place outside the U.S. where you now live or intend to live.)

Mission Village, N.W.R.
Guyana, South America

(b) Show the address to which checks are to be sent.

C/O: Mission Village
P.O. Box 893
Georgetown, Guyana, South America

(c) If you cannot receive checks at the place where you live, please explain why.

No reliable delivery to interior of country.

F-3-b-197c

INFORMATION ABOUT THE WORKER NAMED IN ITEM 1. (If you are the worker, give the information about yourself.)

8. (a) Did the worker live in the U.S. for at least 10 years (i.e., make his temporary or permanent home in the U.S.)? [X] Yes [ ] No

If "Yes," check the block which indicates the total time the worker lived in the U.S.:

[ ] 10–19 Years [ ] 20–29 Years [ ] 30–39 Years

[ ] 40–49 Years [ ] 50–59 Years [X] 60–97 Years

and, indicate the address—or combination of addresses—which will describe 10 years of United States residence.

ADDRESS IN U.S. AT WHICH WORKER LIVED	DATE WORKER'S RESIDENCE BEGAN		DATE WORKER'S RESIDENCE ENDED	
	MONTH	YEAR	MONTH	YEAR
473 Dartmouth Drive Los Angeles, CA.		1947		77

(If additional space is needed, use REMARKS SECTION on last page.)

(b) If the worker named in Item 1 is now deceased, did he die while in the military service of the U.S. or as a result of disease or injury incurred or aggravated in the military service of the U.S.? [ ] Yes [ ] No

If "Yes," explain. N/A

(c) Name the country of which the worker is a citizen. (If deceased, name the country of which he was a citizen at time of death.) → NAME OF COUNTRY OR COUNTRIES: U.S.

An explanation of the special circumstances that affect payment of benefits to beneficiaries outside the U.S. is given in the booklet SSA-609, "Your Social Security Check—While You're Outside the United States"

YOU SHOULD, HOWEVER, MAKE SPECIAL NOTE OF THE FOLLOWING:

I. Your benefits are not payable for any month in which:

A. You (while under age 72) engage in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month, OR

B. The worker (while under age 72) on whose account you are receiving benefits engages in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month.

A person is engaged in noncovered remunerative activity on 7 or more different calendar days a month, regardless of the amount of earnings and the number of hours worked on any particular day, if:

(1) he is carrying on a trade or business outside the United States as sole owner or partner on 7 or more different calendar days a month, and his net earnings from self-employment are not subject to United States social security taxes, OR

(2) he is employed (this includes stand-by employment) to perform services as an employee on 7 or more different calendar days a month and his wages are not subject to United States social security taxes, OR

(3) any combination of (1) and (2), amounting to 7 or more days a month.

II. If you are not a citizen or national of the United States, your benefits may not be payable for any month after you have been outside the United States for 6 consecutive calendar months. When your benefits are withheld for that reason, they cannot be resumed until you have been in the United States for a full calendar month.

(Aliens receiving benefits on the earnings record of a deported wage earner will not receive benefits if they are outside the United States any part of a month following his deportation.)

F-3-b-197c

(Over)

SUPPLEMENTARY MEDICAL INSURANCE

Medicare's Supplementary Medical Insurance helps pay doctor bills and other medical services. Except for certain unusual cases, however, involving medical care in Canada and Mexico, no medicare services are provided outside the United States. There is a monthly premium charged for Supplementary Medical Insurance. Since you may cancel your Supplementary Medical Insurance at any time, and thereby eliminate payment of the premium, you should consider whether you wish to retain Supplementary Medical insurance.

9.	(a) Are you now enrolled in Medicare's SUPPLEMENTARY MEDICAL INSURANCE (Part B)? *If "Yes," answer (b).*	☒ Yes ☐ No
	(b) Do you wish to terminate your enrollment to Supplementary Medical Insurance at this time? *If your answer to 9(b) is "yes", and this is the second time you have terminated such enrollment, you will not again be permitted to enroll for Supplementary Medical Insurance.*	☒ Yes ☐ No

REMARKS *(You may use this space for any explanations. If you need more space, attach a separate sheet.)*

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, by fine, imprisonment or both. I affirm that all information I have given, in this document and elsewhere, is true.

SIGNATURE OF APPLICANT	Date *(Month, day, year)* 6-21-78
Signature *(First name, middle initial, last name) (Write in ink)* SIGN HERE ⇨ Fullman Taylor	Telephone Number(s) at which you may be contacted during the day

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)* C/O: Mission Village, P.O. Box 893

City	Postal Code	Enter Name of Country in which you now live
Georgetown		Guyana, South America

Witnesses are required ONLY if this application has been signed mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, Country & Postal Code)* F-3-b-197d	Address *(Number and street, City, Country and Postal Code)*

☆ U.S. GPO: 1973—543-513/58

P.O. Box 15157
San Francisco, CA
June 21, 1978

Social Security Administration
303 Golden Gate Ave.
San Francisco, CA 94102

Dear Sirs,

As I am moving out of the State of California, effective immediatly, I will no longer be eligible for SSI benefits. Please send me no more checks at my former address 1029 Geary Blvd., San Francisco, 94109.

Thank you very much for your help in this matter.

Yours truly,

565-12-2482

F-3-b-197e

Social Security Medicare Notice

From: Bureau of Health Insurance

If you inquire, please include your Medicare Claim No. 545-48-0030A
Date MAY 05, 1978

ALFRED W TSCHETTER
MISSION VILLAGE
PO BOX 893
GEORGETOWN
GUYANA 894

Your State Public Assistance Agency will pay your Medicare MEDICAL INSURANCE premiums beginning

E-3-b-198

(Month and Year)

JUL 1977

You will receive a Medicare card if you do not have one. If this action entitles you to earlier medical insurance coverage, you will receive a new Medicare card reflecting the date of the earlier coverage.

If you already have medical insurance under Medicare and you have paid the premiums or had them deducted from your social security benefits, the billing or deductions will stop and any overpayment will be refunded to you, less any premiums you may owe for past months.

If you have any questions about your premium payments or your medical insurance protection, telephone or visit your social security office. Please take this notice with you if you visit a social security office.

You may use this notice to show that you are entitled to Medicare Medical Insurance.

Department of Health, Education, and Welfare
Social Security Administration

Form SSA-1614 (1-76)

LANE BRYANT PENSIONER DISCOUNT CARD

F-3-b-199

Catherine Thrash
NAME

Indianapolis — 9-21-65
STORE EMPLOYED — YEAR RETIRED

AUTHORIZED SIGNATURE

THIS CARD EXPIRES ON JANUARY 31, 1979

QUARTERLY PENSION PAYMENT
OF
PENSION PAYABLE IN ADVANCE

DATE	PENSION AMOUNT	MEDICARE	SURGICAL	HOSP.	NOTARY	NET AMOUNT
08/78		24.60				24.60

PLEASE DETACH BEFORE DEPOSITING CHECK AND KEEP FOR YOUR RECORDS

THE PENSION FUND OF LANE BRYANT, INC.
1501 BROADWAY
NEW YORK, N.Y. 10036

Catherine Thrash

F-3-b-200

QUARTERLY PENSION PAYMENT
OF
PENSION PAYABLE IN ADVANCE

DATE	PENSION AMOUNT	MEDICARE	SURGICAL	HOSP.	NOTARY	NET AMOUNT
11/78		24.60				24.60

PLEASE DETACH BEFORE DEPOSITING CHECK AND KEEP FOR YOUR RECORDS

THE PENSION FUND OF LANE BRYANT, INC.
1501 BROADWAY
NEW YORK, N.Y. 10036

Catherine Thrash

F-3-b-201

this card may be used only by the
purchaser whose name appears on
the reverse side, or a member of his
or her immediate family.

F-3-b-202

VETERANS ADMINISTRATION
CENTER
FEDERAL BUILDING, FORT SNELLING
ST. PAUL, MINNESOTA 55111

October 31, 1978

IN REPLY REFER TO: 335/242C1
FN 1525 41 35
XC 03604744

Bernice Thomas
Mission Village
P O Box 893
Georgetown, Guyana 894
FC304

Your monthly insurance check in the amount of $ 39.50 has been stopped because you failed to complete and return either of the two Beneficiary Signature Cards we sent you.

Please complete the enclosed Beneficiary Signature Card (VA Form 24-5798), and return it to this office with a copy of this letter so that payments may be resumed as soon as possible.

Sincerely yours,

for B. Darnell
Finance Officer

Enclosure
VAF 24-5798
Envelope

FL 4-323
Apr 1975

"To care for him who shall have borne the battle, and for his widow, and his orphan." – ABRAHAM LINCOLN

VETERANS ADMINISTRATION
CENTER
FEDERAL BUILDING, FORT SNELLING
ST. PAUL, MINNESOTA 55111

Date: July 28, 1978

In Reply Refer to: FN 1525 41 35
XC 03 604 744
335/242C1

Bernice Thomas
Mission Village
P. O. Box 893
Georgetown Guyana 894 FC304

Beneficiary Signature Cards similar to the one enclosed were mailed to you at the above address on April 4, 1978. The card was to be completed and returned to help us in reviewing the monthly payments of National Service Life Insurance made by the Veterans Administration.

Since a completed card has not been returned to us, we are suspending your monthly payments until we have information you are actually receiving your insurance checks.

It is necessary that you complete the enclosed card by filling in your date of birth and your personal signature. Return the card to us in the self-addressed envelope which requires no postage.

Upon receipt of the required information we will take action to resume monthly payments to you as in the past.

Bev. Darnell
for ROBT. W. MENSSEN
Chief, Operations Section

Enclosures:
VA Form 24-5798
Envelope

F-3-b-203a

"To care for him who shall have borne the battle, and for his widow, and his orphan." – ABRAHAM LINCOLN

PROTECTION OF PRIVACY INFORMATION SHEET

Public Law 93-579 entitled the Privacy Act of 1974 requires that all claimants be informed of the purposes and uses to be made of the information which is solicited. The following is furnished to explain the reason why the information is requested and the general uses to which that information may be put.

AUTHORITY: The Veterans Administration is empowered to solicit the information requested in this form under the authority of Title 38, United States Code.

PURPOSE: The information requested by this form is considered relevant and necessary to determine maximum entitlement to the benefit for which you have applied.

USES: The information will be used in your best interests in determining eligibility to the maximum benefits allowable by law. The responses which are submitted may be disclosed as permitted by law outside the Veterans Administration.

EFFECTS OF NON-DISCLOSURE: Disclosure of the requested information is voluntary. No penalty will be imposed for failure to respond. However, the decision as to entitlement for the benefit you are claiming must then be made on the basis of the available evidence of record. This may result in a delay in the processing of the claim, payment of less than maximum benefits, or complete disallowance of your claim. Failure to provide information in connection with the benefit currently being sought will have no detrimental effect on any other benefit to which you are entitled.

VA FORM JUL 1975 20-8739

F-3-h-203h

F-3-b-204

Supplemental Security Income
Notice of Change

950

From: Department of Health, Education, and Welfare
Social Security Administration

Date: 03-15-78

Social Security Number:
554-50-7066 AI

*ESSIE TOWNS
272 HERMAN
SAN FRANCISCO CA 94102

YOUR CHECKS WILL STOP APRIL 1978.

YOU CANNOT GET SUPPLEMENTAL SECURITY INCOME CHECKS IF YOU ARE OUTSIDE THE UNITED STATES FOR A WHOLE MONTH. SINCE YOU ARE NOW OUTSIDE THE UNITED STATES, WE PLAN TO STOP YOUR CHECKS AS SHOWN ABOVE.

FOR INFORMATION ABOUT ANY CHANGE IN YOUR MEDICAID ELIGIBILITY CAUSED BY THIS ACTION YOU SHOULD GET IN TOUCH WITH YOUR COUNTY WELFARE DEPARTMENT.

Important: See other side for an explanation of your appeal rights and other information. ▶

Form SSA-8151 (12-76)

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Notice of termination of medical insurance benefits

Date: 09/25/78

Claim No: 554-50-7066 A

ESSIE TOWNS
PO BX 893
GEORGETOWN GUYANA SO
AMERICA 894

Date Your Medical Insurance Ends
SEP 30, 1978

As you requested, your medical insurance protection has been stopped. The date your coverage ended is shown above. This notice concerns your medical insurance only. If you have hospital insurance, that coverage will continue.

Medical insurance premiums will no longer be deducted from your social security checks. If any excess premiums have been withheld from your benefits, they will be refunded in a separate check.

Please write to the address shown above if you want information about starting your medical insurance again.

F-3-h-205

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

IRI-71734:PE

Date 8/16/78

Essie Towns
PO Box 893
Georgetown Guyana So
AMERICA

Your Claim Number
554-50-7066 A

F-3-b-206

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Enclosures:
Form SSA-609
Form SSA-1425F

F-3-b-207

8421

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance, Division of International Operations
Post Office Box 1756, Baltimore, Maryland 21203, U.S.A.

Date: 08/21/78

Claim Number:

ESSIE TOWNS 554-50-7066 A
PO BX 893
GEORGETOWN GUYANA SO
AMERICA 894

THE BENEFITS PAYABLE ON THIS SOCIAL SECURITY RECORD HAVE BEEN ADJUSTED.

AS YOU REQUESTED, YOUR MEDICAL INSURANCE PROTECTION HAS BEEN STOPPED EFFECTIVE THE LAST DAY OF 09/78. THIS NOTICE CONCERNS MEDICAL INSURANCE ONLY. IF YOU HAVE HOSPITAL INSURANCE, THAT COVERAGE WILL CONTINUE. MEDICAL INSURANCE PREMIUMS WILL NO LONGER BE DEDUCTED FROM YOUR SOCIAL SECURITY PAYMENTS.

YOUR NEXT PAYMENT WILL BE ADJUSTED FOR ANY MEDICAL INSURANCE PREMIUMS PREVIOUSLY PAID OR FOR ANY PREMIUMS NOW DUE.

IF YOU WANT INFORMATION ABOUT STARTING YOUR MEDICAL INSURANCE AGAIN, PLEASE GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE. THE PEOPLE THERE WILL BE GLAD TO ASSIST YOU AND ANSWER ANY QUESTIONS ABOUT THIS MATTER.

YOUR NEXT PAYMENT FOR $132.10 WILL INCLUDE BENEFITS DUE THROUGH 08/78. AFTER THAT, YOU WILL RECEIVE YOUR REGULAR MONTHLY CHECK FOR $132.10.

SEE ITEM 2 ON THE BACK OF THIS NOTICE FOR MEDICAL INSURANCE PROGRAM INFORMATION.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, PLEASE GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE OR WRITE TO US AT THE ABOVE ADDRESS.

C

Important: See other side for an explanation of your appeal rights and other information. ▶

If you believe this determination is not correct, you may request that your claim be reexamined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office. Residents of the United States, Canada, and Mexico may call, write, or visit any social security office. If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice. If additional evidence is available, you should submit it with your request.

1. Work Outside the U.S.

If you work or own a business outside the U.S.—and you're still under 72—you may not be eligible for social security benefit checks. It's in your best interest to report all employment even though you don't think your work or business will affect your social security checks. By employment, we mean you have a job—even a part-time job—or you are working for yourself as a farmer, writer, sales representative, artisan, etc. Any work as an apprentice must also be reported. If you own a business, you should notify us even if you do not work in the business or receive any income from it.

Send your notice to us by airmail. If your work is not covered by the United States social security program, the general rule is that you can't get a check for any month you've worked or owned a business on any part of 7 or more days while you're under 72. If you can't get a check, then neither can any of your dependents. If your work is covered by the United States social security program, the same annual retirement test will be applied as is applied to beneficiaries in the United States. If you want a fuller explanation, see the people at your nearest U.S. Foreign Service post.

We cannot explain in detail how your checks may be affected by your work. However, upon receipt of your work notice, we will send you a form to fill out. The information you submit on the form will help us decide whether your work or business will affect your checks. You will receive a decision in writing.

2. If You Are Enrolled For Medical Insurance Coverage This Information About Medical Insurance Premiums Applies to You

a. *If monthly social security benefits are being paid to you now—*

Your monthly payment will be adjusted for any premiums you now owe or excess premiums you have paid in advance. After that, 1 month's premium will be withheld from your benefit payment each month.

b. *If monthly social security benefits are not being paid to you now—*

You will be billed for the premiums to pay for your medical insurance. The first bill you receive will cover all premiums due at that time. Further bills will cover the premiums due in advance for a 3-month period.

Each bill will show the months covered and will be sent to you shortly before the payment is due.

c. *Medicare outside the U.S.*

Generally, no Medicare services are provided outside the U.S. The only exceptions are inpatient services provided in Canadian or Mexican hospitals, in limited situations involving emergencies occurring inside the U.S. or while traveling through Canada between Alaska and another State, or where the foreign hospital is nearer the beneficiary's residence in the U.S. than the nearest U.S. hospital which can provide the care needed. There is a monthly premium charged for Supplementary Medical Insurance. Since you may cancel your Supplementary Medical Insurance at any time, and thereby eliminate payment of the premium, you should consider whether you wish to retain your Supplementary Medical Insurance.

You may cancel your medical insurance at any time. Residents of the United States, Canada, and Mexico may call, write, or visit any social security office for assistance. If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration, at the address shown on the reverse side of this notice. The cancellation is not effective until the third month after the month in which it is filed.

If you cancel your medical insurance, you can re-enroll at a later day, but only once. In that case, the premium is increased by ten percent for each full year that you could have been enrolled but were not.

3. Information About Overpayments

If you cannot afford to refund the full overpayment at one time or have your full payment withheld until the overpayment is recovered, get in touch with any social security office to see about repayment by installments or having a smaller amount withheld from your social security payments over a longer period of time. If you live in the United States, Canada, or Mexico, you can get in touch with any social security office. If you live in the Philippines, you can contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice.

Any overpayment must be withheld from benefits or paid back unless both the following statements are true:

a. The overpayment wasn't your fault in any way and you accepted the payment(s) because you thought they were correctly paid to you, and

b. You couldn't meet your necessary living expenses if you had to pay back the overpayment or have it withheld from your social security payments, or if it would be unfair for some other reason.

If you believe you were without fault and that you should not have to repay the money, you should write to us at the address shown on the reverse side of this notice. We will need a statement of your assets, monthly income and expenses to help decide whether repayment would cause you financial hardship.

F-3-b-208

(Use this form ONLY when there is a change to be reported for a United States social security beneficiary)

Social Security
P.O. Box 1756
Baltimore, Maryland 21203 U.S.A.

PRINT NAME OF PERSON ABOUT WHOM REPORT IS MADE

Essie Towns

SOCIAL SECURITY CLAIM NUMBER ON WHICH BENEFITS ARE PAID. It is a nine-digit number (000-00-0000) followed by a letter or a letter and a number ... B, C, D, E, F, or H. Your report cannot be processed without the correct number.

554	50	70[illegible]	[illegible]

Notice: This notice is given pursuant to the Privacy Act of 1974 (5 United States Code 552a). This report is authorized under sections 202, 203, and 225 of the U.S. Social Security Act, as amended (42 United States Code 402, 403, and 425).

It is mandatory that you promptly report certain changes in your circumstances which could affect your continuing eligibility to benefits or your benefit amount. The kinds of changes you must report to social security are listed below on this form.

If you do not report events as shown on this form, you may not be paid some or all of the benefits due you, or you may be overpaid, in which case, you will have to pay back any benefits you received that were not due you. Also, if you conceal or fail to disclose a reporting event with an intent to fraudulently obtain benefits either in a greater amount than is due or when no payment is authorized, you may be FINED, IMPRISONED, or both as provided in section 208 of the U.S. Social Security Act.

The above information about reporting events also applies to representative payees who receive benefits on behalf of another person.

The information you give on this form will be used to determine if you are still eligible for social security benefits and to make sure the amount of your benefit is correct. Other uses which may be made of the information are summarized on the reverse side of this form.

If you need more information to fill out this form, please read "Your social security while you're outside the United States." If you do not have this booklet or if you want help in making a report, get in touch with the people at any U.S. diplomatic or consular office.

Please MAIL THIS REPORT DIRECTLY TO:

Social Security Administration
P.O. Box 1756
Baltimore, Maryland 21203 U.S.A.

Be sure to affix proper postage on the envelope.

CHECK OR FILL IN ONLY THE INFORMATION BEING REPORTED

1. ☒ CHANGE OF ADDRESS *(Print new address after signature below)*
   Check if change is for: ☒ More than 6 mos. ☐ 6 mos. or less

2. ☐ EMPLOYMENT *(As employee or as self-employed person)*		DATE OF EMPLOYMENT
3. ☐ MARRIAGE	GIVE PLACE OF MARRIAGE	DATE OF MARRIAGE
4. ☐ DIVORCE OR ANNULMENT		DATE DECREE FINAL
5. ☐ CHILD OR OTHER CLAIMANT LEFT YOUR CARE		DATE CLAIMANT LEFT YOUR CARE
6. ☐ DEATH		DATE OF DEATH
7. ☐ PERSON RECEIVING DISABILITY BENEFITS		MONTH - DAY - YEAR
☐ Returned to work		
☐ Condition improved		MONTH - DAY - YEAR

8. ☐ CHANGE OF CITIZENSHIP *(If checked give)*:
   No longer citizen of _____ (Country) Now a citizen of _____ (Country)

SIGNATURE OF PERSON MAKING THIS REPORT: Essie Towns

DATE SIGNED: 8 28 78

MAILING ADDRESS (NUMBER AND STREET): P.O. Box 893

CITY OR TOWNSHIP: GEORGETOWN

POSTAL CODE: 894

COUNTRY: GUYANA SOUTH AMERICA

Form SSA-1425F (3-77) Replaces SSA-1425FC and SSA-1425FC NA which are obsolete (OV) 10

Supplemental Security Income
Notice of Change

950

From: Department of Health, Education, and Welfare
Social Security Administration

Date: 08-07-78

Social Security Number:
465-48-2263 AI

*VERA TALLEY
1029 GEARY #9
SAN FRANCISCO CA 94109

YOUR CHECK WILL STOP IN SEPTEMBER 1978.

YOU CANNOT GET SUPPLEMENTAL SECURITY INCOME CHECKS IF YOU ARE OUTSIDE THE UNITED STATES FOR A WHOLE MONTH. SINCE YOU ARE NOW OUTSIDE THE UNITED STATES, WE PLAN TO STOP YOUR CHECKS AS SHOWN ABOVE.

FOR INFORMATION ABOUT ANY CHANGE IN YOUR MEDICAID ELIGIBILITY CAUSED BY THIS ACTION YOU SHOULD GET IN TOUCH WITH YOUR COUNTY WELFARE DEPARTMENT.

F-3-b-209

Important: See other side for an explanation of your appeal rights and other information. ▶

Form SSA-L8151-C1 (2-78) (Formerly SSA-8151)
Prior editions may be used until supply is exhausted

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Date August 15, 1978

Vera M. Talley
Bx 893
Georgetown Guyana
SOUTH AMERICA

Your Claim Number
458-12-9182 B6

F-3-D-210

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Enclosures:
Form SSA-609
Form SSA-1425F

F-3-b-211

(Use this form ONLY when the [illegible] change to be reported for a United States social security beneficiary)

Our address:
Social [illegible]
P.O. Box 17[illegible]
Baltimore, Maryland 21203 U.S.A.

PRINT NAME OF PERSON ABOUT WHOM REPORT IS MADE

VERA M. TALLEY

SOCIAL SECURITY CLAIM NUMBER ON WHICH BENEFITS ARE [illegible] digit number (000-00-0000) followed by a letter or a letter and a [illegible] B, C, D, E, F, or H. Your report cannot be processed without the [illegible] number.

458	12	918[illegible]	LETTER [illegible]

Notice: This notice is given pursuant to the Privacy Act of 1974 (5 United States Code 552a). This report is authorized under sections 202, 203, and 225 of the U.S. Social Security Act, as amended (42 United States Code 402, 403, and 425).

It is mandatory that you promptly report certain changes in your circumstances which could affect your continuing eligibility to benefits or your benefit amount. The kinds of changes you must report to social security are listed below on this form.

If you do not report events as shown on this form, you may not be paid some or all of the benefits due you, or you may be overpaid, in which case, you will have to pay back any benefits you received that were not due you. Also, if you conceal or fail to disclose a reporting event with an intent to fraudulently obtain benefits either in a greater amount than is due or when no payment is authorized, you may be FINED, IMPRISONED, or both as provided in section 208 of the U.S. Social Security Act.

The above information about reporting events also applies to representative payees who receive benefits on behalf of another person.

The information you give on this form will be used to determine if you are still eligible for social security benefits and to make sure the amount of your benefit is correct. Other uses which may be made of the information are summarized on the reverse side of this form.

If you need more information to fill out this form, please read "Your social security while you're outside the United States." If you do not have this booklet or if you want help in making a report, get in touch with the people at any U.S. diplomatic or consular office.

Please MAIL THIS REPORT DIRECTLY TO:

Social Security Administration
P.O. Box 1756
Baltimore, Maryland 21203 U.S.A.

Be sure to affix proper postage on the envelope.

CHECK OR FILL IN ONLY THE INFORMATION BEING REPORTED

1. ☒ CHANGE OF ADDRESS *(Print new address after signature below)*
   Check if change is for: ☒ More than 6 mos. ☐ 6 mos. or less

2. ☐ EMPLOYMENT *(As employee or as self-employed person)*		DATE OF EMPLOYMENT
3. ☐ MARRIAGE	GIVE PLACE OF MARRIAGE	DATE OF MARRIAGE
4. ☐ DIVORCE OR ANNULMENT		DATE DECREE FINAL
5. ☐ CHILD OR OTHER CLAIMANT LEFT YOUR CARE		DATE CLAIMANT LEFT YOUR CARE
6. ☐ DEATH		DATE OF DEATH
7. ☐ PERSON RECEIVING DISABILITY BENEFITS		MONTH - DAY - YEAR
☐ Returned to work		
☐ Condition improved		MONTH - DAY - YEAR

8. ☐ CHANGE OF CITIZENSHIP *(If checked give)*:

No longer citizen of _____ (Country) Now a citizen of _____ (Country)

SIGNATURE OF PERSON MAKING THIS REPORT: Vera M. Talley

DATE SIGNED: 8-25-75

MAILING ADDRESS (NUMBER AND STREET): P.O. Box 893

CITY OR TOWNSHIP	POSTAL CODE	COUNTRY
GEORGETOWN	894	GUYANA - SOUTH AMERICA

Form SSA-1425F (3-77) Replaces SSA-1425FC and SSA-1425FC NA which are obsolete. (OVER)

4. Are there any other persons living in the same household as you and your spouse? ☐ YES ☐ NO
(If "Yes," please give:)

Name	Relationship	Date of Birth	Blind	Disabled	If under 21	
					Student	Married

5. A. Do you (or your spouse) expect to travel or visit outside the United States (50 States or District of Columbia) within the next 12 months? ☐ YES ☐ NO
If Yes, answer B, C, D, and E.

B. Who will be outside the U.S. *(check one)* ☐ You ☐ Spouse ☐ Both

C. Expected date or departure from U.S	D. Expected date of return to the U.S.	E. Name of country(ies) to be visited

6. Have you or your spouse been out of the United States (50 States or District of Columbia) in the last year? ☐ YES ☐ NO
If Yes, explain and give the dates you were gone.

7. Have you or your spouse received or do you expect to receive any of the following this month? For those checked yes, show the amount of the income on a monthly basis in the space to the right of the item(s).

		monthly amount			monthly amount
A. wages	☐ YES ☐ NO	$ ____	E. rents, dividends, interest, royalties	☐ YES ☐ NO	$ ____
B. self employment earnings	☐ YES ☐ NO	$ ____	F. support or contributions from any person or organization	☐ YES ☐ NO	$ ____
C. social security if yes, give claim number ____	☐ YES ☐ NO	$ ____	G. Other income *(specify)* ____	☐ YES ☐ NO	$ ____
D. pension, annuities, or unemployment, workmen's compensation, VA, RRB, Civil Service, or Black Lung benefits? If yes, give claim or ID number(s) ____	☐ YES ☐ NO	$ ____			

8. Do you expect any change *(either increase or decrease)* in the amount of your *(or your spouse's)* income within the next twelve months? ☐ YES ☐ NO
If "Yes," explain

9. Has there been a change in the amount of your (or your spouse's) income (as listed in 7A thru 7 G) in the last year? *(Do not include changes in social security)* ☐ YES ☐ NO
If yes, give the date of change and type of income that changed.

Month/Year ____ Type of Income ____

10. Do you or your spouse own any motor vehicles? ☐ YES ☐ NO
(If "Yes," complete the following:)

Year	Make & Model	Month/yr obtained	Main purpose for which the vehicle is used?

F-3-b-212

Social Security Medicare Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Date
September 12, 1978

Vera M Talley
Box 893
Georgetown GUYANA
SOUTH AMERICA 894

Your Claim Number:
458-12-9182

You have asked us to stop your medical insurance coverage under Medicare. The decision to keep or drop this protection is, of course, one which only you can make. We think you should carefully consider the following facts before your decision becomes final, particularly if you plan to come to the United States to live or to receive medical services.

Hospital and medical insurance pays for services furnished inside the United States. (Inside the United States means within the 50 States, District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.) Therefore, if you plan to come to the United States to live or receive health services, your health insurance protection may be very important to you. If, however, you do not return to the United States to live or receive medical care, these insurance programs will not benefit you. Your decision to drop the medical insurance part of your health insurance would be proper in that case. Stopping your medical insurance does not affect your hospital insurance if you have such coverage. Hospital insurance is provided free of charge and may be used by you if you ever return to the United States.

You may not be eligible to enroll for medical insurance in the future. IF YOU ARE ENDING YOUR SECOND ENROLLMENT, YOU CANNOT SIGN UP AGAIN FOR THIS PROTECTION. If you are ending your first enrollment, you may sign up again during January, February, or March of any year. Coverage would not begin until the following July, and your premiums may be higher than before.

Your medical insurance coverage and your obligation to pay premiums end on 9/30/78
We received your written request for cancellation on 5/2/78, but coverage and the obligation for premiums continue through the end of the calendar quarter after the calendar quarter in which the written request is received. (A calendar quarter is a 3-month period which ends March 31, June 30, September 30, or December 31 of any year.)

If you have any questions, this office will be glad to assist you.

F-3-b-213a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOIUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 224

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
05/19/78	06/19/78
ACCOUNT NUMBER	
00-47393-6	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO.
M	1	1

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	01	4400	8800	11354	00	8800

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	4400	602				13200	602
						13200	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

F-3-b-213b

NUMBER

April 25 1978

11-3
1210

PAY TO THE ORDER OF Cash $176.00

Ten Hundred Seventy Six and Two's DOLLARS

Bank of Montreal
(California)
350 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

VERA TALLEY

Vera Talley

⑆1210⑉0003⑆ 00 47393 6⑈ ⑈0000017600⑈

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
350 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 1978

CASH		
CHECKS	Soc. Sec.	44 00
TOTAL		
LESS CASH RECEIVED		
NET DEPOSIT		44 00

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

JUN 2 1978

F-3-b-213c

11-3 Accounting Services 11-3

⑆1210⑉0003⑆ 00 47393 6⑈ ⑈0000004400⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT.

Bank of Montreal (California) F-3-b-213d

SF
OFFICE

5-22-78
DATE

ADVICE OF MISPLACED CHECK

TO OUR DEPOSITOR: Vera Talley

ACCOUNT NUMBER 00-47393-6

ATTACHED IS THE MISPLACED CHECK (OR OTHER DEBIT ENTRY) THAT WAS PREVIOUSLY CREDITED TO YOUR ACCOUNT 5-17-78 IN THE AMOUNT OF $ 176.00

THIS ITEM WAS REPORTED TO YOU AT THE TIME YOU RECEIVED YOUR STATEMENT.

WE APPRECIATE YOUR PATIENCE IN THIS MATTER.

DATE OF THIS TRANSMITTAL

AUTHORIZED SIGNATURE

AC-60 (4/75)

TRANSMITTAL TO DEPOSITOR

Verd Valley

[redacted]

0300 65701

PAY ANY [illegible], P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3 11-3

JUN -2 78

Bank of Montreal (California)

ADVICE OF MISPLACED CHECK

ACCOUNT NUMBER

TO OUR DEPOSITOR

ATTACHED IS THE MISPLACED CHECK FOR OTHER DEBIT ENTRY THAT WAS PREVIOUSLY CHARGED TO YOUR ACCOUNT

ON _____ IN THE AMOUNT OF

THIS ITEM WAS REPORTED TO YOU AT THE TIME YOU RECEIVED YOUR STATEMENT.

WE APPRECIATE YOUR PATIENCE IN THIS MATTER.

DATE OF THIS TRANSMITTAL _____

AUTHORIZED SIGNATURE

TRANSMITTAL TO DEPOSITOR

F-3-b-214a

Bank of Montreal (California)

STATEMENT OF ACCOUNT

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
06/19/78	07/19/78
ACCOUNT NUMBER	
00-47393-6	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	01	46 90	132 00	153 88	00	132 00

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	46 90	7 06				178 90	7 06
						178 90	

ENDING BALANCE

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LINE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
233 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 7/6 1978

CASH	
CHECKS Soc. Sec.	46.90
TOTAL	
LESS CASH RECEIVED	
NET DEPOSIT	46.90

BANK OF MONTREAL

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

11-3 Bus Services 11-3

F-3-b-219b

⑆1210⑈0003⑆ 00 47395 6⑈ ⑈0000004690⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 15055

PAY A[illegible] E.G.
BK. O[illegible] TREAL
(C[illegible] IIA)
SAN [illegible] O CA.
11-3 11-3

JUL -6 78

F-3-b-215a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
07/19/78	08/18/78
ACCOUNT NUMBER	
00-47393-6	
DISPOSITION CODE: M	NUMBER OF ENCLOSURES: 1	PAGE NO: 1

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	46.90	178.90	203.91	00	178.90

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	46.90	8/03				225.80	8/03
						225.80	

ENDING BALANCE

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LINE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

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SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
555 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 8/3 1978

CASH		
CHECKS	Soc Sec.	46 90
TOTAL		
LESS CASH RECEIVED		
NET DEPOSIT		46 90

BANK OF MONTREAL

AUG

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

11-3 F-3-b-215b

11-3

⑆1210⑈0003⑆ 00 47393 6⑈ ⑈0000004690⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT.

0300 57847

PAY [illegible] P.E.G.
BK. [illegible] TREAL
[illegible] IIA)
SANT[illegible] O CA.
11-3 11-3

AUG -3 78

F-3-b-216a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
08/18/78	09/19/78

ACCOUNT NUMBER: 00-47393-6

DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	4690	22580	24778	00	22580

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	4690	905				27270	905
						$27270	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	[redacted]	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
[illegible] CALIFORNIA STREET
SAN FRANCISCO, CALIF. [illegible]

DATE BANK OF MONTREAL 19 78

VERA [illegible] 11-3
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

CASH	
CHECKS	automatic depo.
TOTAL	
LESS CASH RECEIVED	
TOTAL ITEMS	NET DEPOSIT 46.90

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

F-3-b-216b

⑆1210⑈0003⑆ 00 42397 6⑈ ⑈0000004690⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 00929

PAY / [illegible] E.G.
BK. [illegible] EAL
[illegible]
[illegible] CA.
11-3 11-3

SEP -5 78

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
299 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 9/4 19 78

CASH		
CHECKS	automatic dep.	
TOTAL		
LESS CASH RECEIVED		
NET DEPOSIT	46	90

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

F-3-h-217

⑆1210⑈0003⑆ 00 47393 6⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
299 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 7/6 19 78

CASH		
CHECKS	Soc. Sec.	46 90
TOTAL		
LESS CASH RECEIVED		
NET DEPOSIT	46	90

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

F-3-h-218

⑆1210⑈0003⑆ 00 47393 6⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
299 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 8/3 19 78

CASH		
CHECKS	Soc Sec.	46 90
TOTAL		
LESS CASH RECEIVED		
NET DEPOSIT	46	90

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

VERA TALLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

F-3-h-219

⑆1210⑈0003⑆ 00 47393 6⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

TO PURCHASE TREASURY BILLS AT THE BANK OF GUYANA: F-3-b-220

1. The first step is to go in and talk to the peoplex at the Bank of Guyana and find out what the cost of, say G$500,000 worth of Treasury Bills. There will be a different price on different days because instead of investing the full $500,000, for Treasury Bills they add your interest to your investment to equal $500,000. Treasury Billa are renewable every three months.
For example:
Next Opening selling date will be June 16:

A. The value of the T-bills is $500,000.
B. At 1 1/2% interest, you would purchase for approx $492,500
C. On maturity date, Sept 16, they will be worth $500,000.
D. If they are redeemed before Sept 16, you would get whatever interest is accumulated so far.
E. If you redeem before they have been held at least 8 days, you lose part of your investment. Interest does not accumulate until after 8 day

2. You do not have to buy only on opening selling dates. That is the date of the highest interest paid, you can purchase any time of the period. That is why you must check with the Bank of Guyana before drawing your money out of an account. Bank of Guyana will tell you exactly what amount you must draw out to invest for any set figure you give them. For example, if you want to invest for $500,000 and the interest period is half gone. They will give you a figure of approx $496,250 to draw out of your account to give the full $500,000 on maturity date.

3. Interest is calculated at any time and the Treasury Bills can be redeemed at any time in the period of 3 months which they run.

4. If you want them reinvested on exactly their selling date, you can sign a form which will automatically reinvest them until you can go in and sign the forms.

5. To get the money out of the External Account that you want to invest, you must get a letter or some statement from the bank you are drawing the money out of, that the account that the Guyana dollars you are going to invest in the Treasury bills is from an external account. The letter does not need to state what the money is going to be used for, but only what type of account it came from. When you take the check and the letter to the Bank of Guyana, you must get a letter from them signed by Mr. Brandt of the foreign reserve department stating that the money being invested in Treasury bills came from an external account and is there fore transferrable back into U.S. dollars or back into the external account.

6. Mr. Brandt of the Bank of Guyana is also the person you see about getting a letter granting permission for the interest on the Treasury Bills to be deposited into an external account. You cannot deposit the interest into an external acount otherwise.

7. To find the department where you buy the Treasury bills, go up the stairs and go to the left hand side of the long counter and state your business

Michael Prokes
Peoples Temple Agricultural Project

CEMENT MASONS SOUTHERN CALIFORNIA PENSION TRUST

DETACH THIS STUB BEFORE DEPOSITING THIS CHECK.

SOC. SEC. NO.	PENSION PER
464184492	08/01/78
PENSION AMOUNT	
142.00	
	YEAR TO DATE
	GROSS AMOUNT
	1,136.00

Thomas

F-3-b-222 13851

PENSION CHECK NO.

0013851

CEMENT MASONS SOUTHERN CALIFORNIA PENSION TRUST

DETACH THIS STUB BEFORE DEPOSITING THIS CHECK.

SOC. SEC. NO.	PENSION PER
464184492	07/01/78
PENSION AMOUNT	
142.00	
	YEAR TO DATE
	GROSS AMOUNT
	994.00

E. Thomas

F-3-b-221 12918

PENSION CHECK NO.

0012918

CEMENT MASONS SOUTHERN CALIFORNIA PENSION TRUST

DETACH THIS STUB BEFORE DEPOSITING THIS CHECK.

SOC. SEC. NO.	PENSION PER
464184492	10/01/78
PENSION AMOUNT	
142.00	
	YEAR TO DATE
	GROSS AMOUNT
	1,420.00

E. Thomas

F-3-b-224 15740

PENSION CHECK NO.

0015740

CEMENT MASONS SOUTHERN CALIFORNIA PENSION TRUST

DETACH THIS STUB BEFORE DEPOSITING THIS CHECK.

SOC. SEC. NO.	PENSION PER
464184492	09/01/78
PENSION AMOUNT	
142.00	
	YEAR TO DATE
	GROSS AMOUNT
	1,278.00

E. Thomas

F-3-b-223 14789

PENSION CHECK NO.

0014789

CEMENT MASONS SOUTHERN CALIFORNIA PENSION TRUST

DETACH THIS STUB BEFORE DEPOSITING THIS CHECK.

SOC. SEC. NO.	PENSION PER
464184492	11/01/78
PENSION AMOUNT	
142.00	
	YEAR TO DATE
	GROSS AMOUNT
	1,562.00

E. Thomas

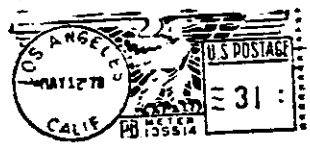
F-3-b-225 16686

PENSION CHECK NO.

0016686

CEMENT MASONS TRUSTS FOR SOUTHERN CALIFORNIA
500 S. VIRGIL AVENUE
LOS ANGELES, CALIFORNIA 90020

F-3-b-226a



E. Thomas
P.O. Box 893
Georgetown
Guyana, South America

F-3-b-22b

CEMENT MASONS SOUTHERN CALIFORNIA HEALTH AND WELFARE FUND
11 COUNTIES CEMENT MASONS VACATION SAVINGS PLAN
CEMENT MASONS SOUTHERN CALIFORNIA PENSION TRUST
CEMENT MASONS JOINT APPRENTICESHIP TRUST
800 SOUTH VIRGIL AVENUE
LOS ANGELES, CALIFORNIA 90020
386-2901

May 1, 1978

TO: ALL ACTIVE ELIGIBLE CEMENT MASONS and RETIRED CEMENT MASONS Eligible for Health & Welfare Benefits for the Eligibility Period, April 15, 1978 through October 14, 1978

FROM: CEMENT MASONS SOUTHERN CALIFORNIA HEALTH & WELFARE FUND

Gentlemen:

Effective May 1, 1978, the Cement Masons Southern California Health & Welfare Fund became self-funded on Hospital/Medical benefits. You have previously been mailed the booklet describing these hospital/medical benefits.

Enclosed you will find new claim forms to be used for claims which were started after May 1, 1978. These completed forms should be mailed to the Claims Office, P. O. Box 76935, Los Angeles, California 90076 also indicated on the back of the form.

Hospital/Medical benefits for Retired employees and their dependents are LIMITED to certain special catagories of Retirees. ONLY if you meet the eligibility requirements as explained on page 7 and ONLY if you are entitled to Hospital/Medical benefits prior to May 1, 1978 are the benefits applicable to you or your dependents.

It is important that you do not use the Aetna Claim form for claims which were started after May 1, 1978. Claims started prior to May 1, 1978 should be reported to the Claims Dept., Aetna Life & Casualty at the following address: Aetna Life & Casualty, P.O. Box 1909, Long Beach, California 90801 (Group Policy Number 361618).

We have also enclosed your Health & Welfare identification card for the Eligibility Period, April 15, 1978 through October 14, 1978.

The Vision Service Plan brochure is enclosed for your convenience. The Vision Plan applies ONLY to Active Eligible Cement Masons and their eligible dependents.

If you have any questions, please do not hesitate to contact this office.

Sincerely,

CEMENT MASONS ADMINISTRATIVE OFFICE

F-3-b-226c

HEALTH BENEFIT CLAIM FORM

CEMENT MASONS SOUTHERN CALIFORNIA
HEALTH AND WELFARE
P.O. BOX 76935
LOS ANGELES, CA. 90076

PATIENT & MEMBER INFORMATION (To be completed by Member) (PLEASE TYPE OR PRINT)

1. Member Name (First, Middle Initial, Last)
2. Members S.S. No.
3. Union Local No.
4. Check Plan: Active ☐ Retired ☐ Self Pay ☐
5. Members Address (Street, City, State, Zip Code)
6. Patient's Name (First, Middle Initial, Last)
7. Patient's Date of Birth Mo. Day Yr.
8. Full Time Student (Complete only if claim for child, age 19 to 23) ☐YES ☐NO IF YES, WHERE
9. Patient's Address (If different from Member)
10. Patient's Sex ☐MALE ☐FEMALE
11. Patient's Relationship to Member ☐Self ☐Spouse ☐Child ☐Other
12. Is patient covered under other Health Benefit Plan? ☐YES ☐NO
If yes, check type ☐Group ☐Private ☐Medicare
Enter Plan Name and Address of Claims Offices:
13. Was Condition Related To:
A. Patient's Employment? ☐ YES ☐ NO
B. An Accident? ☐ YES ☐ NO
14. If an Accident date _____ 19 ____ and time _____ ☐ A.M. ☐ P.M.
Description (how & where):
15. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE
I authorize the Release of any Medical Information Necessary to Process this request.
SIGNED DATE
16. Authorize payment of medical benefits to undersigned physician or supplier for
SIGNED (Member or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION (To be Completed By Provider)

17. DATE OF ILLNESS INJURY PREGNANCY
18. DATE OF FIRST SYMPTOMS DATE OF ACCIDENT DATE OF LMP
19. DATE FIRST CONSULTED YOU FOR THIS CONDITION
20. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ NO ☐ YES
21. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK
22. DATES OF PATIENTS DISABILITY — TOTAL DISABILITY FROM DATE THROUGH DATE — PARTIAL DISABILITY FROM DATE THROUGH DATE
23. NAME OF REFERRING PHYSICIAN
24. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES — DATE ADMITTED — DATE DISCHARGED
25. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (If Other Than Home or Office)
26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NOS. 1, 2, 3, ETC. IN COL. D)
1
2
3

27. A DATE OF EACH SERVICE	B PLACE OF SERVICE *SEE CODES BELOW	C DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES) PROCEDURE CODE		D DX NO.	E CHARGES (EXPLAIN UNUSUAL CIRCUMSTANCES IN COLUMN C)	F LEAVE BLANK

28. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, TELEPHONE NO., AND IDENTIFICATION NO.
29. PROVIDERS TAX NO.
30. TOTAL CHARGES $.
31. AMOUNT PAID $.
32. BALANCE DUE $.
33. PROFESSIONAL STATUS MD ☐ CHIROPRACTOR ☐ PSYCHOLOGIST ☐ OTHER ☐
34. ACCEPT ASSIGNMENT ☐ YES ☐ NO
35. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGN HERE
36. DATE SIGNED
37. YOUR PATIENT'S ACCOUNT NO.

*PLACE OF SERVICE CODES
01.-(IH)-INPATIENT HOSPITAL
02.-(OH)-OUTPATIENT HOSPITAL
03.-(O)-DOCTOR'S OFFICE
04.-(H)-PATIENT'S HOME
05.-(SNF)-SKILLED NURSING FACILITY
06.-(IL)-INDEPENDENT LABORATORY
07.-(LTC)-LONG TERM CARE
08.-(IC)-INTERMEDIATE CARE
09.-(C)-CLINIC
10.-(OL)-OTHER LOCATIONS

CM102

See Other Side

HEALTH PLAN BENEFITS
REQUEST FORM

Cement Masons Southern California
HEALTH AND WELFARE FUND
P.O. Box 76935
Los Angeles, CA. 90076

HOW TO REQUEST BENEFITS

1. COMPLETE THE "PATIENT INFORMATION" (ITEMS 1 THROUGH 16) ON THE REVERSE SIDE OF THIS FORM.

   If you wish your medical benefits paid directly to your doctor, sign item 16. A separate form should be submitted for each family member.

2. HAVE YOUR DOCTOR COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" (ITEMS 17 THROUGH 37) OR ATTACH COMPLETELY ITEMIZED BILLS.

   An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered and the nature of the condition being treated.

3. COMPLETION OF ITEMS 17 THROUGH 37 IS REQUIRED FROM THE PRIMARY ATTENDING PHYSICIAN ONLY. A SEPARATE CLAIM FORM IS NOT NECESSARY FOR RELATED X-RAY LABORATORY, ANESTHESIA, ASSISTANT SURGEON OR AMBULANCE SERVICES. ATTACH ITEMIZED BILLS.

4. SEND THE COMPLETED "BENEFIT REQUEST FORM" AND ANY BILLS DIRECTLY TO THE CLAIMS OFFICE, INDICATED BELOW.

IMPORTANT REMINDER

Please be sure you have provided the **employee's Social Security Number.**

Please mail all Hospital, Physician or Supplier Bills to

Cement Masons Southern California
Health and Welfare Fund
P. O. Box 76935
Los Angeles, California 90076
(213) 385-1762

F-3-W-226d

HEALTH BENEFIT CLAIM FORM

CEMENT MASONS SOUTHERN CALIFORNIA
HEALTH AND WELFARE
P.O. BOX 76935
LOS ANGELES, CA. 90076

PATIENT & MEMBER INFORMATION (To be completed by Member) (PLEASE TYPE OR PRINT)

1. Member Name (First, Middle Initial, Last)
2. Members S.S. No.
3. Union Local No.
4. Check Plan: Active ☐ Retired ☐ Self Pay ☐
5. Members Address (Street, City, State, Zip Code)
6. Patient's Name (First, Middle Initial, Last)
7. Patient's Date of Birth Mo. Day Yr.
8. Full Time Student (Complete only if claim for child, age 19 to 23) ☐YES ☐NO IF YES, WHERE
9. Patient's Address (If different from Member)
10. Patient's Sex ☐MALE ☐FEMALE
11. Patient's Relationship to Member ☐Self ☐Spouse ☐Child ☐Other
12. Is patient covered under other Health Benefit Plan? ☐YES ☐NO
If yes, check type ☐Group ☐Private ☐Medicare
Enter Plan Name and Address of Claims Office:
13. Was Condition Related To:
A. Patient's Employment? ☐ YES ☐ NO
B. An Accident? ☐ YES ☐ NO
14. If an Accident date _____ 19 ____ and time _____ ☐ A.M. ☐ P.M.
Description (how & where):
15. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE
I authorize the Release of any Medical Information Necessary to Process this request.
SIGNED DATE
16. Authorize payment of medical benefits to undersigned physician or supplier for
SIGNED (Member or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION (To be Completed By Provider)

17. DATE OF ILLNESS INJURY PREGNANCY
18. DATE OF FIRST SYMPTOMS DATE OF ACCIDENT DATE OF LMP
19. DATE FIRST CONSULTED YOU FOR THIS CONDITION
20. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ NO ☐ YES
21. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK
22. DATES OF PATIENTS DISABILITY — TOTAL DISABILITY FROM DATE THROUGH DATE — PARTIAL DISABILITY FROM DATE THROUGH DATE
23. NAME OF REFERRING PHYSICIAN
24. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES — DATE ADMITTED — DATE DISCHARGED
25. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (If Other Than Home or Office)
26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NOS. 1, 2, 3, ETC. IN COL. D)
1
2
3

27. A DATE OF EACH SERVICE	B PLACE OF SERVICE *SEE CODES BELOW	C DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES) PROCEDURE CODE		D DX NO.	E CHARGES (EXPLAIN UNUSUAL CIRCUMSTANCES IN COLUMN C)	F LEAVE BLANK

28. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, TELEPHONE NO., AND IDENTIFICATION NO.
29. PROVIDERS TAX NO.
30. TOTAL CHARGES $.
31. AMOUNT PAID $.
32. BALANCE DUE $.
33. PROFESSIONAL STATUS MD ☐ CHIROPRACTOR ☐ PSYCHOLOGIST ☐ OTHER ☐
34. ACCEPT ASSIGNMENT ☐ YES ☐ NO
35. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGN HERE
36. DATE SIGNED
37. YOUR PATIENT'S ACCOUNT NO.

*PLACE OF SERVICE CODES
01.-(IH)-INPATIENT HOSPITAL
02.-(OH)-OUTPATIENT HOSPITAL
03.-(O)-DOCTOR'S OFFICE
04.-(H)-PATIENT'S HOME
05.-(SNF)-SKILLED NURSING FACILITY
06.-(IL)-INDEPENDENT LABORATORY
07.-(LTC)-LONG TERM CARE
08.-(IC)-INTERMEDIATE CARE
09.-(C)-CLINIC
10.-(OL)-OTHER LOCATIONS

CM102

See Other Side

28

HEALTH PLAN BENEFITS
REQUEST FORM

Cement Masons Southern California
HEALTH AND WELFARE FUND
P.O. Box 76935
Los Angeles, CA. 90076

HOW TO REQUEST BENEFITS

1. COMPLETE THE "PATIENT INFORMATION" (ITEMS 1 THROUGH 16) ON THE REVERSE SIDE OF THIS FORM.

   If you wish your medical benefits paid directly to your doctor, sign item 16. A separate form should be submitted for each family member.

2. HAVE YOUR DOCTOR COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" (ITEMS 17 THROUGH 37) OR ATTACH COMPLETELY ITEMIZED BILLS.

   An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered and the nature of the condition being treated.

3. COMPLETION OF ITEMS 17 THROUGH 37 IS REQUIRED FROM THE PRIMARY ATTENDING PHYSICIAN ONLY. A SEPARATE CLAIM FORM IS NOT NECESSARY FOR RELATED X-RAY LABORATORY, ANESTHESIA, ASSISTANT SURGEON OR AMBULANCE SERVICES. ATTACH ITEMIZED BILLS.

4. SEND THE COMPLETED "BENEFIT REQUEST FORM" AND ANY BILLS DIRECTLY TO THE CLAIMS OFFICE, INDICATED BELOW.

IMPORTANT REMINDER

Please be sure you have provided the **employee's Social Security Number.**

Please mail all Hospital, Physician or Supplier Bills to:

Cement Masons Southern California
Health and Welfare Fund
P. O. Box 76935
Los Angeles, California 90076
(213) 385-1762

CEMENT MASONS SOUTHERN CALIFORNIA
HEALTH AND WELFARE FUND
500 South Virgil Avenue, Suite 200
Los Angeles, California 90020

NOTICE TO ELIGIBLES

If you are eligible in the Health and Welfare Trust Fund, please print on spaces to the right.

USE INK

Employee Name _____ →

Employee Social Security No. _____ →

Employee Union Local No. _____ →

Present this card when obtaining services for you or your eligible dependents.

Claims Office
P.O. Box 76935
Los Angeles, Calif. 90076

F-3-b-e

CEMENT MASONS
HEALTH & WELFARE FUND

_____ (Member)

_____ (Soc. Sec. Number)

M- _____ (Local Union #)

_____

CEMENT MASONS TRUSTS FOR SOUTHERN CALIFORNIA
500 SOUTH VIRGIL AVENUE
LOS ANGELES, CALIFORNIA 90020

E THOMAS 464-18-4492
P O BOX 893
GEORGETOWN
GUYANA SOUTH AMERICA [redacted]

F-3-b-227a

CEMENT MASONS SOUTHERN CALIFORNIA
HEALTH AND WELFARE FUND
500 South Virgil Avenue, Suite 200
Los Angeles, California 90020

NOTICE TO ELIGIBLES

If you are eligible in the Health and Welfare Trust Fund, please print on spaces to the right.

USE INK

Employee Name → _____ (Member)

Employee Social Security No. → _____ (Soc. Sec. Number)

Employee Union Local No. → M- _____ (Local Union #)

Present this card when obtaining services for you or your eligible dependents.

Claims Office F-3-b-227b
P.O. Box 76935
Los Angeles, Calif. 90076

CEMENT MASONS
HEALTH & WELFARE FUND

Note to Hospitals

If you wish to certify the benefits payable to this individual, contact the claims office shown below, giving them the identifying information on the reverse of this card and the admitting diagnosis. If the patient is other than the employee, also give the patient's name, birthdate and relationship to the employee.

FORWARD ALL BILLS DIRECTLY TO THE

Claims Office
P.O. Box 76935
Los Angeles, Calif. 90076
(213) 385-1762

This card is for identification purposes.

IDENTIFICATION OF BENEFITS

This card will identify the specific benefits provided for the eligible members of the Health and Welfare Trust Fund named through April 14, 1979.

NOTICE TO EMPLOYEES

The Plan covers your eligible dependents. They will be identified through your eligibility—you do not have to write their names and Social Security numbers on this card.

E-3-b-228

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
06/19/78	07/19/78
ACCOUNT NUMBER	
00-47365-0	
DISPOSITION CODE: M	NUMBER OF ENCLOSURES:	PAGE NO: 1

ETTA THOMPSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	00	00	2160 42	2160 42	00	2160 42

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
						2160 42	

ENDING BALANCE

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

F-3-b-229

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333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
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Bank of Montreal (California)

STATEMENT OF ACCOUNT

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08/18/78	09/19/78
ACCOUNT NUMBER	
00-47365-0	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M		1

ETTA THOMPSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	00	00	2160.42	2160.42	00	2160.42

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
						2160.42	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

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SEE REVERSE SIDE FOR IMPORTANT INFORMATION

SOCIAL SECURITY ADM
1355 SUTTER
SAN FRANCISCO CA 94109

Refer to:

Date: 8-14-78
Phone: 556-9242

ETTA THOMPSON 950
1029 GEARY 371
SAN FRANCISCO CA 94109 A

4F

Dear SSI Recipient:

Every year, each SSI (gold check) recipient is required by law to provide information and evidence regarding his/her continuing financial eligibility for those SSI benefits. In order to continue to receive the monthly checks and Medi-Cal benefits, you must complete this redetermination process. You must complete the forms and provide any documents or evidence necessary to support the answers you gave.

Please come in between 9:00 AM and 1:00 PM on 21 AUG 1978. Be sure you have responded to this letter by phone, by mail, or in person no later than the above date.

If you are unable to come into the office, answer all the questions on both forms, sign both forms, and mail them in with any of the items listed below that apply to your case. BE SURE YOU READ THE LIST BELOW. ALSO BE SURE YOU HAVE COMPLETED EACH ITEM AND SIGNED EACH FORM.

When you come in for your interview, BE SURE TO BRING THE FOLLOWING:

1) Complete the attached forms but do not sign (unless you are mailing them in)
2) Your latest checking account statement and/or savings passbook (if any)
3) Your pay stubs or self employment records (if you have worked recently)
4) Your vehicle registration (if you own a motor vehicle)
5) Your life insurance policies (if you own any)
6) Proof of U.S. citizenship (birth certificate. voter registration, etc.) or of your alien status (green or blue card)
7) Your most recent award letter if you receive any monthly benefits besides Social Security or SSI (for example, union pension, VA benefits)
8) Rent receipt or rental agreement (if you live with someone else, we need a signed statement from the head of the household or roommate which states total living expenses, amount you contribute, and how many people share the household)

REMEMBER: The law requires that you complete this redetermination process if you are to continue to receive SSI gold checks. FAILURE TO COMPLETE THIS PROCESS WILL RESULT IN SUSPENSION OF YOUR SSI BENEFITS!

REDETERMINATION UNIT

NOTE: PLEASE RETURN THIS LETTER TO US

F-3-b-230a

NOTIFY US IMMEDIATELY IF YOU:

a) change your address

b) move into or out of another's household

c) are admitted and expect to stay 30 days or longer in a public institution, hospital, skilled nursing facility, intermediate care facility, nursing home or jail

d) are released from one of the above named facilities

e) leave the United States (50 States or District of Columbia) for 30 days or more

f) separate from your husband or wife, or start living together again after separation

g) marry, or your marriage ends by divorce or annulment, or your husband or wife dies

h) your wife/husband have an increase or decrease in income from work, unemployment check, pension, or other payments

i) receive help or money from someone else to pay your bills

j) sell your home, real estate, car, or other personal property

k) or your wife/husband have a bank account which increases in value

l) are disabled or blind and your condition improves

m) are 18 to 22 and you start or stop attending school regularly

SOMEONE SHOULD REPORT IF:

a) you become unable to manage your own funds

b) you stop treatment required for drug addiction or alcoholism

c) you should die

A PENALTY MAY BE IMPOSED FOR FAILURE TO REPORT CHANGES

F-3-b-230b

SUPPLEMENT TO FORM SSA 8200

1. Have you cooking or food storage facilities? (California only).....Yes__No__

2. Have you or your spouse (or former spouse ever:
   a. Been in military service?.....Yes__No__
   b. Worked for a railroad?.....Yes__No__
   c. Worked for a Federal, state, county, or city government?.....Yes__No__
   d. Worked for a private employer with a pension plan?.....Yes__No__
   e. Belonged to a union with a pension plan?.....Yes__No__

3. Have you or your spouse sold property or given away money or property in the last 12 months?.....Yes__No__

4. Does anyone help you take care of yourself (for example, help you with eating, dressing, bathing, taking medication, caring for your room or moving about)?.....Yes__No__

5. I have received reporting instructions and agree to notify SSA immediately of changes which occur. I understand failure to report an event could result in a penalty deduction of $25 to $100 if the report is not made within 30 days after the end of the quarter in which the event occurred.....Yes__No__

F-3-D-230c

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration

Form Approved
OMB No. 72-R0986

DO NOT WRITE IN THIS SPACE

STATEMENT FOR DETERMINING CONTINUING ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME PAYMENTS

I understand that the information requested below is needed to determine my continuing eligibility to Supplemental Security Income and/or State supplementary payments and may result in an adjustment of my payment. I also understand that this information may be used in determining my eligibility for State Medicaid or social services.

(CIRCLE ONE) C NC

INTERVIEWER'S INITIALS

Show your first name, middle initial, last name, and social security number in the spaces below, if you are married, your spouse's name and number should be shown below your name and number.

Your Name	Social Security Number

Spouse's Name	Social Security Number

1. Check (✓) the block below which shows your present marital status

A. ☐ Single, widowed or divorced	B. ☐ Married and living with spouse	C. ☐ Married and living in a separate household from your spouse. Enter date you and your spouse began living apart _____

If married, widowed, or divorced in the last year, give date of event: Month/Year _____

2. Check and complete the section below which best describes your living arrangement. Do not check more than one box.

You live in a

☐ house ☐ apartment ☐ mobile home ☐ room ☐ Other (specify) _____

(If you have checked one of the above, complete (A) or (B) below)

OR

You live in a

☐ rest or retirement home ☐ hospital ☐ nursing home ☐ school ☐ rehabilitation center ☐ other institution

(If you have checked one of the above, complete (C) below)

A. ☐ If you own, are buying, or rent your home give:

Amount of monthly mortgage or rental payment _____

Estimated current market value of home you own or are buying _____

Does anyone else pay part or all of your mortgage, real estate taxes, rent, or utilities?

☐ YES ☐ NO

B. ☐ If someone else owns or is buying or rents your home give:

Their Name _____

Their relationship to you _____

Do they furnish food? ☐ YES ☐ NO

C. Name and Address of Institution _____

F-3-h-230d

_____ Date of Admission _____

3. Has there been a change in your living arrangements in the last year? ☐ YES ☐ NO
If yes, give the date of most recent change Month/Year _____

Form SSA-8260 (8-76) 21 AUG 1976

F-3-b-231

Supplemental Security Income Notice of Overpayment

From: Department of Health, Education, and Welfare
Social Security Administration

OPL, 556-2345

Etta Thompson
C/O Mission Village
P.O. Box 898
Georgetown, Guyana
South America

Date: June 21, 1978

Social Security Number: 450-20-5494

We have determined that you received $ 885.88 more in supplemental security income payments than you were due.

A person is not eligible to receive SSI if he or she goes outside the U.S. and stays for period of over 30 calendar days. According to our records, you left the U.S. on 10/14/77, but continued to receive your SSI through April 1978. You were not entitled to any of the checks you received November 1977 through April 1978.

Please read the other side of this notice for important information concerning your right to appeal this determination of overpayment.

You have certain additional rights with respect to overpayments whether or not you agree that you have been overpaid. Under the law, an overpayment must be withheld from payments due you, or paid back unless *both* of the following were true:

1. You were not at fault in any way in connection with the overpayment and you cashed the check(s) because you thought it was (they were) due, *and*

2. You could not meet your current necessary living expenses if you had to pay the money back, or repayment would be unfair for some other reason. (To make this decision, we may need additional information about your resources and your monthly income and expenses.)

If you think you meet both of the conditions which would allow us to waive repayment of the overpayment, phone, write or visit a social security office within 30 days after getting this notice to explain why you should not have to repay the overpayment.

Otherwise, you should refund the overpayment of $ 885.88 Make your check or money order payable to the Social Security Administration, social security number 450-20-5494, and mail it in the enclosed envelope. (If you cannot refund the full amount, please get in touch with us about making monthly installments.)

11.	Do you or your spouse own life insurance policies?	☐ YES	☐ NO
	If yes, is the total amount of the face value on the policy (or all policies) for you or your spouse more than $1500?	☐ YES	☐ NO
12.	How much cash money do you and your spouse have available to you?	$	

13. Do you, either individually or jointly with anyone else, have any of the following? For those checked yes, show the current value.

			current value		current value
A. Checking account	☐ YES	☐ NO	$ _____	E. Money in safe deposit box(es) ☐ YES ☐ NO	$ _____
B. Savings account (any kind)	☐ YES	☐ NO	$ _____		
C. Savings Certificates	☐ YES	☐ NO	$ _____	F. Other negotiable item(s) ☐ YES ☐ NO	$ _____
D. Stocks, Bonds, Notes	☐ YES	☐ NO	$ _____		

14.	Do you or your spouse have any household or personal item valued at more than $500? If yes, explain in remarks.	☐ YES	☐ NO
15.	Do you or your spouse have any other money or property of any kind? *(Such as houses, mobile homes, other building, land, equipment, business, or any other item not considered elsewhere on this statement).* If yes, explain in remarks.	☐ YES	☐ NO
16.	Have you or your spouse sold any property, or given money or property to any person in the last year? If yes, give the date _____ and explain in remarks.	☐ YES	☐ NO

17. Complete this question only if payments are based on blindness or disability and you are under age 22.

A. Are you now regularly attending school? If Yes, answer B and C.	☐ YES	☐ NO
B. Do you expect to remain in school for the next 12 months *(except for summer vacation and other periods that school is not in session)?*	☐ YES	☐ NO

C. If there has been, or will be a change in your school attendance explain, giving the date school attendance started or stopped, and the name and address of the school you were attending, or are now attending or expect to attend.

_____

_____

_____

Remarks: *(you may use this space for any explanations. If you need more space attach a separate sheet.)*

YOUR RESPONSIBILITIES

You must notify the Social Security Administration immediately if there is a change in your address, living arrangements, family size or composition, income, resources, or if you leave the United States (50 States or District of Columbia) and expect to be absent for 30 consecutive days.

If you are receiving payments as a blind or disabled individual you must also report any improvement in your medical condition or your return to work.

Do you agree to notify the Social Security Administration immediately if any of the above events occur? ☐ YES ☐ NO

Do you give your permission for the Social Security Administration to check any information you have given on, or in connection with, this statement and to ask your employers for information about your wages? ☐ YES ☐ NO

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal or State law or both. I affirm that all information I have given in this document is true.

SIGNATURES

Your Signature *(First Name, Middle Initial, Last Name) (Write in ink.)*	Date *(Month, day, year)*
SIGN HERE ▶	
Spouse's Signature *(First Name, Middle Initial, Last Name)*	Telephone Number(s) at which you may be contacted during the day.
SIGN HERE ▶	

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Enter name of county (if any) in which you live

NOTE: If residence address is different from mailing address; show residence address in "Remarks"

Your statement does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing who know you must sign below, giving thier full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State, and Zip Code)*	Address *(Number and street, City, State, and Zip Code)*

NOTE: If you are filing this statement on behalf of another person, please print below, your full name, followed by your title or relationship to the recipient (for example, "John J. Jones, Son")

Name *(First, middle initial, last)*	Title or Relationship

F-3-b-232

PO Box 893
Georgetown, Guyana
So. America
July 10, 1978

Dept of Health, Education and Welfare
Social Security Administration

Re: Etta Thompson 450-20-5494
SSA 8171 dated June 21, 1978

Dear Sirs,

In response to your recent letter, I would like to request an appeal based on the following information

(1) I did leave on October 14, 1977, which would still leave me eligible for the Nov. 1, '77 award

(2) I notified you immediately of my move and my change of address fully meeting my reporting responsibilities.

(3) I would like to review your verification that the checks from November 77 thru April '78 were actually received by me and/or deposited in my account.

(4) I would like a total review because I feel I am not responsible for any of the benefits continuing, nor should I have to repay them.

Thank you for your time and consideration

Very sincerely

Etta Thompson

F-3-b-233

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
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(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
07/19/78	08/18/78
ACCOUNT NUMBER	
00-47365-0	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M		1

ETTA THOMPSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	00	00	216042	216042	00	216042

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
						216042	

ENDING BALANCE

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

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SEE REVERSE SIDE FOR IMPORTANT INFORMATION

F-3-b-234

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333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOIUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 224

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
05/19/78	06/19/78
ACCOUNT NUMBER	
00-47365-0	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M		1

ETTA THOMPSON
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	00	00	2160 42	2160 42	00	2160 42

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
						2160 42	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

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AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

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SEE REVERSE SIDE FOR IMPORTANT INFORMATION

F-3-b-235

Supplemental Security Income Notice of Overpayment

From: Department of Health, Education, and Welfare
Social Security Administration

OPL, 556-9236

Etta Thompson
C/O Mission Village
P.O. Box 898
Georgetown, Guyana
South America

Date: July 26, 1978

Social Security Number: 450-20-5494

We have determined that you received $ 885.88 more in supplemental security income payments than you were due.

A person is not eligible to receive SSI if he or she goes outside the U.S. and stays for period of over 30 calendar days. According to our records, you left the U.S. on 10/14/77, but continued to receive your SSI through April 1978. You were not entitled to any of the checks you received November 1977 through April 1978.

Please read the other side of this notice for important information concerning your right to appeal this determination of overpayment.

You have certain additional rights with respect to overpayments whether or not you agree that you have been overpaid. Under the law, an overpayment must be withheld from payments due you, or paid back unless *both* of the following were true:

1 You were not at fault in any way in connection with the overpayment and you cashed the check(s) because you thought it was (they were) due, *and*

2 You could not meet your current necessary living expenses if you had to pay the money back, or repayment would be unfair for some other reason. (To make this decision, we may need additional information about your resources and your monthly income and expenses.)

If you think you meet both of the conditions which would allow us to waive repayment of the overpayment, phone, write or visit a social security office within 30 days after getting this notice to explain why you should not have to repay the overpayment.

Otherwise, you should refund the overpayment of $ 885.88 Make your check or money order payable to the Social Security Administration, social security number 450-20-5494, and mail it in the enclosed envelope. (If you cannot refund the full amount, please get in touch with us about making monthly installments.)

IMPORTANT-SECOND NOTICE !!!

F-3-b-236

8638

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance, Division of International Operations
Post Office Box 1756, Baltimore, Maryland 21203, U.S.A.

Date: 08/28/78

Claim Number:

ETTA THOMPSON 450-20-5494 A
BOX 893
GEORGETOWN GUYANA 894

THE BENEFITS PAYABLE ON THIS SOCIAL SECURITY RECORD HAVE BEEN ADJUSTED.

AS YOU REQUESTED, YOUR MEDICAL INSURANCE PROTECTION HAS BEEN STOPPED EFFECTIVE THE LAST DAY OF 07/78. THIS NOTICE CONCERNS MEDICAL INSURANCE ONLY. IF YOU HAVE HOSPITAL INSURANCE, THAT COVERAGE WILL CONTINUE. MEDICAL INSURANCE PREMIUMS WILL NO LONGER BE DEDUCTED FROM YOUR SOCIAL SECURITY PAYMENTS.

YOUR NEXT PAYMENT WILL BE ADJUSTED FOR ANY MEDICAL INSURANCE PREMIUMS PREVIOUSLY PAID OR FOR ANY PREMIUMS NOW DUE.

IF YOU WANT INFORMATION ABOUT STARTING YOUR MEDICAL INSURANCE AGAIN, PLEASE GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE. THE PEOPLE THERE WILL BE GLAD TO ASSIST YOU AND ANSWER ANY QUESTIONS ABOUT THIS MATTER.

YOUR NEXT PAYMENT FOR $218.20 WILL INCLUDE BENEFITS DUE THROUGH 09/78. AFTER THAT, YOU WILL RECEIVE YOUR REGULAR MONTHLY CHECK FOR $201.80.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, PLEASE GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE OR WRITE TO US AT THE ABOVE ADDRESS.

C

Important: See other side for an explanation of your appeal rights and other information. ▶

F-3-b-237

REPORT TO SOCIAL SECURITY ADMINISTRATION BY PERSON OUTSIDE THE UNITED STATES

(Use this form ONLY when there is a change to be reported for a United States social security beneficiary)

Our address is:
Social Security Administration
P.O. Box 1756
Baltimore, Maryland 21203 U.S.A.

PRINT NAME OF PERSON ABOUT WHOM REPORT IS MADE: LEONY WRIGHT

SOCIAL SECURITY CLAIM NUMBER ON WHICH BENEFITS ARE PAID. It is a nine digit number (000-00-0000) followed by a letter or a letter and a number, such as A, B, B1, C, C1, D, E, F, or H. Your report cannot be processed without the correct claim number.

			LETTER
428	22	0091	[illegible]

Notice: This notice is given pursuant to the Privacy Act of 1974 (5 United States Code 552a). This report is authorized under sections 202, 203, and 225 of the U.S. Social Security Act, as amended (42 United States Code 402, 403, and 425).

It is mandatory that you promptly report certain changes in your circumstances which could affect your continuing eligibility to benefits or your benefit amount. The kinds of changes you must report to social security are listed below on this form.

If you do not report events as shown on this form, you may not be paid some or all of the benefits due you, or you may be overpaid, in which case, you will have to pay back any benefits you received that were not due you. Also, if you conceal or fail to disclose a reporting event with an intent to fraudulently obtain benefits either in a greater amount than is due or when no payment is authorized, you may be FINED, IMPRISONED, or both as provided in section 208 of the U.S. Social Security Act.

The above information about reporting events also applies to representative payees who receive benefits on behalf of another person.

The information you give on this form will be used to determine if you are still eligible for social security benefits and to make sure the amount of your benefit is correct. Other uses which may be made of the information are summarized on the reverse side of this form.

If you need more information to fill out this form, please read "Your social security while you're outside the United States." If you do not have this booklet or if you want help in making a report, get in touch with the people at any U.S. diplomatic or consular office.

Please MAIL THIS REPORT DIRECTLY TO:
Social Security Administration
P.O. Box 1756
Baltimore, Maryland 21203 U.S.A.

Be sure to affix proper postage on the envelope.

CHECK OR FILL IN ONLY THE INFORMATION BEING REPORTED

1. ☐ CHANGE OF ADDRESS *(Print new address after signature below)*
   Check if change is for: ☐ More than 6 mos. ☐ 6 mos. or less
2. ☐ EMPLOYMENT *(As employee or as self-employed person)* ..... DATE OF EMPLOYMENT
3. ☐ MARRIAGE ..... GIVE PLACE OF MARRIAGE ..... DATE OF MARRIAGE
4. ☐ DIVORCE OR ANNULMENT ..... DATE DECREE FINAL
5. ☐ CHILD OR OTHER CLAIMANT LEFT YOUR CARE ..... DATE CLAIMANT LEFT YOUR CARE
6. ☐ DEATH ..... DATE OF DEATH
7. ☐ PERSON RECEIVING DISABILITY BENEFITS
   - ☐ Returned to work ..... MONTH - DAY - YEAR
   - ☐ Condition improved ..... MONTH - DAY - YEAR
8. ☐ CHANGE OF CITIZENSHIP *(If checked give):*
   No longer citizen of _____ *(Country)* Now a citizen of _____ *(Country)*

SIGNATURE OF PERSON MAKING THIS REPORT: Leony Wright
DATE SIGNED: 6-30-79

MAILING ADDRESS (NUMBER AND STREET): P.O. Box 893

CITY OR TOWNSHIP: GEORGETOWN
POSTAL CODE:
COUNTRY: GUYANA - SOUTH AMERICA

Form SSA-1429F (3-77) Replaces SSA-1429FC and SSA-1429FC NA which are obsolete. (OVER)

F-3-b-238

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

IRI-71736:PE

Leony Wright
% Mission Village
P.O. Box 893
Georgetown
GUYANA 894

Date
June 8, 1978

Your Claim Number
428-22-0096 B2, C1

This notice also applies to your children.

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Enclosures:
Form SSA-609
Form SSA-1425F

F-3-b-239

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

IRI-71734:PE

Louise Williams
Mission Village
PO Box 893
Georgetown
GUYANA

Date
June 12, 1978

Your Claim Number
463-34-2951 A

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Your next check for $2,018.80 represents your benefits for October 1977 through May 1978. It has been adjusted for any medical insurance premiums due. We will contact you soon regarding your request to terminate your enrollment to Supplementary Medical Insurance.

Because of the amendments to the Social Security Act, your monthly benefit amount was increased to $272.90 effective June 1978.

Enclosures:
Form SSA-609
Form SSA-1425F

F-3-b-240

REPORT TO SOCIAL SECURITY ADMINISTRATION BY PERSON OUTSIDE THE UNITED STATES

(Use this form ONLY when there is a change to be reported for a United States social security beneficiary)

Our address is:
Social Security Administration
P.O. Box 1756
Baltimore, Maryland 21203 U.S.A.

PRINT NAME OF PERSON ABOUT WHOM REPORT IS MADE: LOUISE WILLIAMS

SOCIAL SECURITY CLAIM NUMBER ON WHICH BENEFITS ARE PAID: It is a nine digit number (000-00-0000) followed by a letter or a letter and a number, such as A, B, B₁, C, C₁, D, E, F, or H. Your report cannot be processed without the correct claim number.

			LETTER
463	34	2951	

Notice: This notice is given pursuant to the Privacy Act of 1974 (5 United States Code 552a). This report is authorized under sections 202, 203, and 225 of the U.S. Social Security Act, as amended (42 United States Code 402, 403, and 425).

It is mandatory that you promptly report certain changes in your circumstances which could affect your continuing eligibility to benefits or your benefit amount. The kinds of changes you must report to social security are listed below on this form.

If you do not report events as shown on this form, you may not be paid some or all of the benefits due you, or you may be overpaid, in which case, you will have to pay back any benefits you received that were not due you. Also, if you conceal or fail to disclose a reporting event with an intent to fraudulently obtain benefits either in a greater amount than is due or when no payment is authorized, you may be FINED, IMPRISONED, or both as provided in section 208 of the U.S. Social Security Act.

The above information about reporting events also applies to representative payees who receive benefits on behalf of another person.

The information you give on this form will be used to determine if you are still eligible for social security benefits and to make sure the amount of your benefit is correct. Other uses which may be made of the information are summarized on the reverse side of this form.

If you need more information to fill out this form, please read "Your social security while you're outside the United States." If you do not have this booklet or if you want help in making a report, get in touch with the people at any U.S. diplomatic or consular office.

Please MAIL THIS REPORT DIRECTLY TO:
Social Security Administration
P.O. Box 1756
Baltimore, Maryland 21203 U.S.A.

Be sure to affix proper postage on the envelope.

CHECK OR FILL IN ONLY THE INFORMATION BEING REPORTED

1. ☐ CHANGE OF ADDRESS *(Print new address after signature below)*
   Check if change is for: ☐ More than 6 mos. ☐ 6 mos. or less
2. ☐ EMPLOYMENT *(As employee or as self-employed person)* ..... — DATE OF EMPLOYMENT
3. ☐ MARRIAGE ..... — GIVE PLACE OF MARRIAGE — DATE OF MARRIAGE
4. ☐ DIVORCE OR ANNULMENT ..... — DATE DECREE FINAL
5. ☐ CHILD OR OTHER CLAIMANT LEFT YOUR CARE ..... — DATE CLAIMANT LEFT YOUR CARE
6. ☐ DEATH ..... — DATE OF DEATH
7. ☐ PERSON RECEIVING DISABILITY BENEFITS
   - ☐ Returned to work ..... — MONTH - DAY - YEAR
   - ☐ Condition improved ..... — MONTH - DAY - YEAR
8. ☐ CHANGE OF CITIZENSHIP *(If checked give):*
   No longer citizen of _____ (Country) Now a citizen of _____ (Country)

SIGNATURE OF PERSON MAKING THIS REPORT: Keeine Williams — DATE SIGNED: July 12, 1978

MAILING ADDRESS (NUMBER AND STREET): PO Box 893

CITY OR TOWNSHIP: Georgetown Guyana — POSTAL CODE: — COUNTRY: S. America

Form SSA-1429F (3-77) Replaces SSA-1429FC and SSA-1429FC HA which are obsolete. (OVER)

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Notice of termination of medical insurance benefits

Date: 09/25/78

Claim No: 463-34-2951 A

LOUISE WILLIAMS
MISSION VILLAGE
PO BOX 893
GEORGETOWN
GUYANA 894

Date Your Medical Insurance Ends
SEP 30, 1978

As you requested, your medical insurance protection has been stopped. The date your coverage ended is shown above. This notice concerns your medical insurance only. If you have hospital insurance, that coverage will continue.

Medical insurance premiums will no longer be deducted from your social security checks. If any excess premiums have been withheld from your benefits, they will be refunded in a separate check.

Please write to the address shown above if you want information about starting your medical insurance again.

F-3-b-241

F-3-b-242

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Date

Clara L. Winters
Bx 893
Georgetown
GUYANA

July 5, 1978
Your Claim Number
[redacted]

b6
b7c

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

You should complete the enclosed form and return it to us immediately in the enclosed envelope which requires postage. If we do not receive the completed form within 90 days, benefit payments will be stopped until it is received.

Enclosures: SSA-21, Envelope
Form SSA-609
Form SSA-1425F

mailed 8/21/78
to 3330 Geary
& envelope to
1333 Mac Donald
Ave, Richmond
enclosed

F-3-h-243a

sent again 8/21/78

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. R0506

SUPPLEMENT TO CLAIM OF PERSON OUTSIDE THE UNITED STATES

(To be completed by or on behalf of person who is, was, or will be outside the U.S.)

For social security purposes a person is outside the United States if he is physically outside the 50 States, the District of Columbia, Puerto Rico, Virgin Islands, Guam, and American Samoa.

1.	NAME OF WORKER ON WHOSE EARNINGS THIS CLAIM IS BASED Leon H. Wesley	WORKER'S SOCIAL SECURITY NUMBER [redacted]
2.	PRINT YOUR NAME (If you are filing application on behalf of an incompetent adult, enter his or her name in this space and answer all subsequent questions on this questionnaire FOR him.) [illegible]	YOUR U.S. SOCIAL SECURITY NUMBER 565-28-6142

b6
b7c

CITIZENSHIP

3. (a) At the time of your birth, of what country (or countries) were you a citizen? — NAME OF COUNTRY (or countries): U.S.

(b) Have you ever become a citizen of any country other than the country or countries shown in (a) above? ☐ Yes ☒ No
If "Yes," give the name of the country and explain how and when citizenship was acquired.

(c) Of what country (or countries) are you now a citizen? — NAME OF COUNTRY (or countries): USA

(d) Do you have a valid passport? ☒ Yes ☐ No
If "Yes," give the following information:

DATE ISSUED	PASSPORT NUMBER	NAME OF GOVERNMENT THAT ISSUED PASSPORT
[illegible]	[redacted]	USA

IF YOU ARE A U.S. CITIZEN, answer (e) and (f) below. If You are not a U.S. citizen, go on to question 4.

(e) After becoming a U.S. citizen, have you ever been employed by a foreign government either in a civilian or military capacity? ☐ Yes ☐ No
If "Yes," explain when and where.

(f) After becoming a U.S. citizen have you ever been convicted of any crime against the U.S.? ☐ Yes ☐ No
If "Yes," explain what crime(s), when, and where.

PHYSICAL PRESENCE IN THE U.S.

4. (a) Have you ever been physically present in the U.S. at any time? ☒ Yes ☐ No

(b) Are you now physically present in the U.S.? ☐ Yes ☐ No

If "Yes," enter the date you plan to leave the U.S. — MONTH, DAY, YEAR: 3/24/78

If "No," enter the date you left the U.S. — MONTH, DAY, YEAR:

(c) When do you plan to return to the U.S.? — MONTH, DAY, YEAR: over 1 year

(d) Did you enter or leave the U.S. at any time during the past 24 months? ☐ Yes ☒ No
If "Yes," give the following information concerning each of your arrivals and departures.

DATE OF ARRIVAL (Month, day, year)	DATE OF DEPARTURE (Month, day, year)	ADDRESSES OF PLACES YOU LIVED OR VISITED IN THE U.S.

SSA 21 (Over)

F-3-b-243b

EMPLOYMENT – SELF-EMPLOYMENT

A person is employed if he performs services for someone else and receives cash payment or other compensation for these services. This includes any part-time work or summer work by a child, or work by a child as an apprentice.

A person is self-employed if he has a business either by himself or with one or more partners. Some examples of self-employment are raising fruit, crops or livestock for sale, taking in sewing or laundry, providing services as a tutor, lawyer, or physician, etc. The amount of earnings (or loss) has no effect on whether the person is considered self-employed.

5. (a) Have you been employed or have you engaged in self-employment outside the U.S. during any of the past 24 months including the present month? ☐ Yes ☒ No

(b) If you are still in the U.S. will you engage in employment or self-employment outside the U.S.? ☐ Yes ☒ No

Give the following information about your employment or self-employment outside the U.S.

NAME AND ADDRESS OF EMPLOYER (If self employed, show "self" and name and address of your trade or business.)	TYPE OF BUSINESS	EMPLOYMENT OR SELF-EMPLOYMENT	
		DATE BEGAN OR WILL BEGIN	DATE ENDED (If not ended, leave blank)

CHANGES TO BE REPORTED PROMPTLY TO THE SOCIAL SECURITY ADMINISTRATION

Notify the Social Security Administration promptly if, while outside the U.S.:

(1) you become employed or self-employed while under age 72

(2) there is any change in your citizenship

(3) you go into a different country for more than 1 month.

6. (a) Do you agree to notify the Social Security Administration promptly when any of the above events occur? ☒ Yes ☐ No

FAILURE TO REPORT EMPLOYMENT OR SELF-EMPLOYMENT PROMPTLY AS AGREED MAY RESULT IN THE LOSS OF MONTHLY BENEFITS

(b) Do you also agree to return promptly any check for benefits received by you if you are not entitled to it? ☒ Yes ☐ No

MAILING ADDRESS

All social security checks are sent to the beneficiary's place of residence unless there is a valid reason for sending checks in care of another person or to another address.

7. (a) Give the complete address of residence abroad. *(The place outside the U.S. where you now live or intend to live.)*

Mission Village, N.W.R.
Guyana, South America

(b) Show the address to which checks are to be sent.

c/o: Mission Village
P.O. Box 893
Georgetown, Guyana, South America

(c) If you cannot receive checks at the place where you live, please explain why.

No reliable mail service in interior of country.

INFORMATION ABOUT THE WORKER NAMED IN ITEM 1. *(If you are the worker, give the information about yourself.)*

8. (a) Did the worker live in the U.S. for at least 10 years (i.e., make his temporary or permanent home in the U.S.)? ☒ Yes ☐ No

If "Yes," check the block which indicates the total time the worker lived in the U.S.:

☐ 10–19 Years ☐ 20–29 Years ☐ 30–39 Years

☐ 40–49 Years ☐ 50–59 Years ☒ 60–97 Years

and, indicate the address—or combination of addresses—which will describe 10 years of United States residence.

ADDRESS IN U.S. AT WHICH WORKER LIVED	DATE WORKER'S RESIDENCE BEGAN		DATE WORKER'S RESIDENCE ENDED	
	MONTH	YEAR	MONTH	YEAR
532 Cutter, Pittsburg Ca.		71		75
1300 40th Pl. L.A. Ca		47		51
1719 Main Ave. Richmond		75		77

(If additional space is needed, use REMARKS SECTION on last page.)

(b) If the worker named in Item 1 is now deceased, did he die while in the military service of the U.S. or as a result of disease or injury incurred or aggravated in the military service of the U.S.? ☐ Yes ☒ No

If "Yes," explain.

(c) Name the country of which the worker is a citizen. *(If deceased, name the country of which he was a citizen at time of death.)* → NAME OF COUNTRY OR COUNTRIES: U.S.

An explanation of the special circumstances that affect payment of benefits to beneficiaries outside the U.S. is given in the booklet SSA-609, "Your Social Security Check--While You're Outside the United States"

YOU SHOULD, HOWEVER, MAKE SPECIAL NOTE OF THE FOLLOWING:

I. Your benefits are not payable for any month in which:

A. You (while under age 72) engage in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month, OR

B. The worker (while under age 72) on whose account you are receiving benefits engages in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month.

A person is engaged in noncovered remunerative activity on 7 or more different calendar days a month, regardless of the amount of earnings and the number of hours worked on any particular day, if:

(1) he is carrying on a trade or business outside the United States as sole owner or partner on 7 or more different calendar days a month, and his net earnings from self-employment are not subject to United States social security taxes, OR

(2) he is employed (this includes stand-by employment) to perform services as an employee on 7 or more different calendar days a month and his wages are not subject to United States social security taxes, OR

(3) any combination of (1) and (2), amounting to 7 or more days a month.

II. If you are not a citizen or national of the United States, your benefits may not be payable for any month after you have been outside the United States for 6 consecutive calendar months. When your benefits are withheld for that reason, they cannot be resumed until you have been in the United States for a full calendar month.

(Aliens receiving benefits on the earnings record of a deported wage earner will not receive benefits if they are outside the United States any part of a month following his deportation.)

(Over)

SUPPLEMENTARY MEDICAL INSURANCE

Medicare's Supplementary Medical Insurance helps pay doctor bills and other medical services. Except for certain unusual cases, however, involving medical care in Canada and Mexico, no medicare services are provided outside the United States. There is a monthly premium charged for Supplementary Medical Insurance. Since you may cancel your Supplementary Medical Insurance at any time, and thereby eliminate payment of the premium, you should consider whether you wish to retain Supplementary Medical Insurance.

9.	(a) Are you now enrolled in Medicare's SUPPLEMENTARY MEDICAL INSURANCE (Part B)? *If "Yes," answer (b).*	[X] Yes [ ] No
	(b) Do you wish to terminate your enrollment to Supplementary Medical Insurance at this time? *If your answer to 9(b) is "yes", and this is the second time you have terminated such enrollment, you will not again be permitted to enroll for Supplementary Medical Insurance.*	[X] Yes [ ] No

REMARKS *(You may use this space for any explanations. If you need more space, attach a separate sheet.)*

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, by fine, imprisonment or both. I affirm that all information I have given, in this document and elsewhere, is true.

SIGNATURE OF APPLICANT

Signature *(First name, middle initial, last name) (Write in ink)*

SIGN HERE [signature]

Date *(Month, day, year)* 3/22/78

Telephone Number(s) at which you may be contacted during the day

Mailing Address *(Number and Street, Apt. No., P.O. Box, or Rural Route)* c/o: Mission Village, P.O. Box 893

City: Georgetown | Postal Code: | Enter Name of Country in which you now live: Guyana

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below giving their full addresses.

1. Signature of Witness

Address *(Number and Street, City, Country and Postal Code)*

2. Signature of Witness

Address *(Number and Street, City, Country and Postal Code)*

U.S. GPO 1973-545-513:59

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

CHICAGO, ILLINOIS

Check No. 97,342,549
SYMBOL 2074

United States Treasury

PAY TO THE
ORDER OF MARY N WALKER
274 HERMAN ST.
SAN FRAN CA 94117

MONTH	DAY	YEAR
07	01	77

49

WA79713C

DOLLARS	CTS.
$***232	99

1
RR REG ANN

Charles S. Taylor
NATIONAL DISBURSING OFFICER

DO NOT FOLD, BENDING OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

⑈20746⑈ ⑆0000-0051⑆ 97342549⑈

F-3-h-244

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

CHICAGO, ILLINOIS

Check No. 97,257,459
SYMBOL 2074

United States Treasury 1 51/000

PAY TO THE ORDER OF MARY N WALKER
274 HERMAN ST
SAN FRAN CA 94117

WA797130 59 1

DOLLARS	CTS.
$***218	45

RR REG ANN

MONTH	DAY	YEAR
06	01	78

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

⑈20746⑈ ⑆0000⑉0051⑆ 972574592⑈

F-3-h-245

F-3-b-246

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

PHILADELPHIA, PENNSYLVANIA

Check No. 65,188,691
SYMBOL 3054

United States Treasury

PAY TO THE ORDER OF MORREL WILLIS
802 FELL ST
SAN FRANCISCO CA 94117

[redacted]

91 A 6

DOLLARS	CTS.
$***153	70

MONTH	DAY	YEAR
09	01	78

SOC SEC FOR AUG

b6
b7c

⑈30547⑈ ⑆0000-0051⑆ 651886917⑈

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

PHILADELPHIA, PENNSYLVANIA

Check No. 11,762,439
SYMBOL 3054

DO NOT FOLD, STAPLE OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

United States Treasury

PAY TO THE
ORDER OF MCRREL WILLIS
8C2 FELL ST
SAN FRANCISCO CA 94117

[redacted]

MONTH	DAY	YR
10	03	78

39 A G

DOLLARS	CTS.
$***153	70

SOC SEC FOR SEP

b6
b7c

⑈30547⑈ ⑆0000⑈0051⑆ 11762439⑈

F-3-b-247

[redacted]

Standard Form 1180-C (Rev. 6-75)
4 TREASURY FRM 7000 [redacted]

ADVICE OF REQUEST FOR STOP PAYMENT

(Forward to Payee or Claimant)

1. Date of Request	2. Reason	3. Amount	4. Date of Check	5. Symbol	6. Check Number
5-24-78	☒ Non-receipt ☐ Other: ☐ "x" if confirmation ☐ Lost ☐ Stolen ☐ "x" if correction	640.50	2-13-78	3053	14 890 627

7. Payee's Name (enter only when not identical to the claimant's name in Box 9)

8. Remarks (including identification or reference)	9. Claimant of Check and Current Address	
[redacted]	[redacted]	DO NOT SEND

10. NOTICE TO PAYEE OR CLAIMANT:

Your claim is being handled by the Bureau of Government Financial Operations, Division of Check Claims, Washington, D.C. 20227. Please read and carefully observe the instructions on the other side of this form.

TO PAYEE OR CLAIMANT: F-3-b-248

1180-117

b6
b7c

[redacted]

[redacted]

TO PAYEE OR CLAIMANT:

1. IF YOU HAVE ALREADY CASHED THIS CHECK, THIS FORM SHOULD BE DESTROYED.

2. OTHERWISE, the United States Treasury will give active attention to your claim and advise you further as soon as possible. In the meantime, you should take no further action unless you have additional information to submit such as a change in your mailing address. Any additional information should be submitted over your signature and must accurately describe the check (items 5 through 6 on the other side). INITIAL PROCESSING OF YOUR CLAIM MAY TAKE UP TO SIX WEEKS FROM THE DATE OF THIS REQUEST (Item 1).

3. If this is not the check in question, *do not write* the Bureau of Government Financial Operations, Division of Check Claims, but write to the Government Department or Agency which authorized the issuance of the check(s) and give your identification number. You should furnish that office sufficient information to identify the check in question.

4. If you uncover the ORIGINAL check before you receive a substitute check, YOU MUST SIGN AND DATE THIS FORM BELOW AND MAIL IT, BEFORE CASHING YOUR CHECK, to the Bureau of Government Financial Operations, Division of Check Claims, Stop Pay Branch, Washington, D.C. 20227. IF THE CHECK WAS ISSUED TO PAYEES JOINTLY, BOTH MUST SIGN BELOW.

DEPARTMENT OF THE TREASURY
BUREAU OF GOVERNMENT FINANCIAL OPERATIONS
DIVISION OF CHECK CLAIMS
STOP PAY BRANCH
WASHINGTON, D.C. 20227

I/We have recovered the check described in this form and will negotiate it. Please remove the stop payment.

Aug 18 1978 Emma M. Wingey
(Date) (Signature) (Signature)

F-3-b-249

8211

Social Security Benefit Information

From: Bureau of Retirement and Survivors Insurance, Division of International Operations
Post Office Box 1756, Baltimore, Maryland 21203, U.S.A.

Date: 07/17/78

Claim Number: [redacted] A

ERMA M WINFREY
BOX 893
GEORGETOWN GUYANA 894

A GENERAL INCREASE IN SOCIAL SECURITY BENEFITS RECENTLY RAISED MONTHLY PAYMENTS. WE WERE UNABLE TO DOUBLE CHECK THE ACCURACY OF ALL OF THE INCREASES BEFORE THE DATE THE FIRST PAYMENTS WERE PREPARED. A SMALL PERCENTAGE WERE LATER FOUND TO BE INACCURATE. YOURS WAS ONE OF THESE. WE ARE SORRY FOR ANY INCONVENIENCE THIS MAY HAVE CAUSED. YOUR CORRECTED NEW RATE IS SHOWN BELOW.

YOUR NEXT PAYMENT WILL BE FOR $109.80. IT WILL INCLUDE THE DIFFERENCE BETWEEN THE AMOUNT YOU RECEIVED AT THE OLD RATE AND THE AMOUNT YOU SHOULD HAVE BEEN PAID AT THE NEW RATE. IT WILL COVER BENEFITS DUE YOU THROUGH 7/78. AFTER THAT, YOU WILL RECEIVE YOUR REGULAR MONTHLY PAYMENT OF $109.70.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, PLEASE GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE OR WRITE TO US AT THE ABOVE ADDRESS.

C

Important: See other side for an explanation of your appeal rights and other information. ▶

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Check No. 81,578,712
SYMBOL 3127

United States Treasury 15-51/000

PAY TO THE ORDER OF BESSIE M WESLEY
PO BX 1241
RICHMOND CA 94804

BIRTH	DAY	YEAR
07	03	78

573-09-2371
12 D 5
SOC SEC FOR JUN

DOLLARS	CTS.
$***103	30

DO NOT FOLD, SPINDLE OR MUTILATE
X NOW YOUR ENDORSER - ADJUSTS IDENTIFICATION

013
Clarence S. Taylor
REGIONAL DISBURSING OFFICER

⑈31273⑈ ⑆0000-0051⑆ 815787126⑈

F-3-b-250

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Check No. 81,578,712
SYMBOL 3127

DO NOT FOLD, STAPLE OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE ID FOR VERIFICATION

United States Treasury 15-51 / 000

PAY TO THE ORDER OF BESSIE M WESLEY
PO BX 1241
RICHMOND CA 94804

MONTH	DAY	YEAR
07	03	78

573-09-2371
12 D 5
SOC SEC FOR JUN

DOLLARS	CTS.
$***103	30

013
Clarence L. Taylor
SERVICE REGIONAL DISBURSING OFFICER

⑈31273⑈ ⑆0000-0051⑆ 81578712⑈

F-3-b-051

F-3-b-252

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Chec No. 30,194,103
SYMBOL 3127

United States Treasury 15-51/000

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

PAY TO THE ORDER OF BESSIE M WESLEY
PO BX 1241
RICHMOND CA 94804

DAY	YEAR
08 03	78

573-09-2371
03 D 5
SCC SEC FCR JUL

DOLLARS	CTS.
$***103	30

⑈31273⑈ ⑆0000⑉0051⑆ 301941035⑈

DEPARTMENT OF THE TREASURY
BUR OF GOV'T FINANCIAL OPERATIONS
DIVISION OF DISBURSEMENT
P.O. BOX 3579
SAN FRANCISCO, CALIFORNIA 94119

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300

PRESORTED
FIRST CLASS MAIL
POSTAGE AND FEES PAID
DEPARTMENT OF THE TREASURY
PERMIT NO G-4
SAN FRANCISCO, CA

POSTMASTER:
RETURN THIS LETTER
IMMEDIATELY IF ADDRESSEE:
MOVED - AND LEFT NO
FORWARDING ADDRESS
DECEASED - SHOW DATE OF
DEATH IF KNOWN:
ADDRESSEE:
SEE REVERSE IF YOU HAVE
MOVED.

S

1419 MAINE AVE
RICHMOND, CA 94804

POSTMASTER:
REQUESTED DELIVERY
DATE IS THE
3RD
DAY OF THE MONTH
OR THE FIRST
DELIVERY DATE
THEREAFTER

S-PW24-

TRY DIRECT DEPOSIT
SAFE - CONVENIENT - RELIABLE

F-3-b-253

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Check No. 84,728,400
SYMBOL 3127

United States Treasury 15-51/000

PAY TO THE ORDER OF BESSIE M WESLEY
PO BX 1241
RICHMOND CA 94804

573-09-2371
OC D 5
SOC SEC FOR AUG

DOLLARS	CTS.
$***103	30

MTH	DAY	YEAR
09	01	78

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER ... REQUIRE IDENTIFICATION

013
Clarence S. Taylor
CENTRAL DISBURSING OFFICER

⑈31273⑈ ⑆0000-0051⑆ 847284009⑈

1419 MAINE AVE
RICHMOND, CA 94804

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

SAN FRANCISCO, CALIFORNIA

Check No. 33,451,530
SYMBOL 3127

United States Treasury 15-51/000

PAY TO THE ORDER OF BESSIE M WESLEY
PO BX 1241
RICHMOND CA 94804

DOLLARS	CTS.
$***103	30

YR	DAY	YR
10	03	78

573-09-2371
3C D 5
SOC SEC FOR SEP

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER - ACQUIRE IDENTIFICATION

013
Clarence S. Taylor
CHIEF DISBURSING OFFICER

⑈31273⑈ ⑆0000⑉0051⑆ 334515302⑈

DEPARTMENT OF THE TREASURY
BUR OF GOV'T FINANCIAL OPERATIONS
DIVISION OF DISBURSEMENT
P.O. BOX 3379
SAN FRANCISCO, CALIFORNIA

PRESORTED
FIRST CLASS MAIL
POSTAGE AND FEES PAID
DEPARTMENT OF THE TREASURY
SAN FRANCISCO, CA

POSTMASTER
RETURN THIS LETTER
IMMEDIATELY
MOVED
FORWARDING ADDRESS
DECEASED
DEATH OR KNOWN
ADDRESSEE
SEE REVERSE
MOVED

1419 MAINE AVE
RICHMOND, CA 94804

TRY DIRECT DEPOSIT
SAFE - CONVENIENT - RELIABLE

...ce pain in the chest
...ficulty swallowing, or
...ess
...rapid large weight los
...medical examination w
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...other diseases.
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...osed to asbestos, i
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3RD
DAY OF THE MONTH
FOR THE FIRST
DELIVERY DATE
THEREAFTER

F-3-b-254

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
RECEIPT AND TRANSMITTAL FORM

We acknowledge receipt of the following payment:

No. N 1028041

REMITTER

DATE	NAME OF BENEFICIARY	RSDI / SSI	SOCIAL SECURITY NO.	BIC/ARC
9/22/78	Bessie Wesley	☐ RSDI ☒ SSI	565-28-6142	

CK. OR M.O. NO.	CASH	AMOUNT	NAME OF REMITTER	DATE OF CHECK OR M.O.	REASON FOR PAYMENT
9,812,934		219.10	James Randolph	9/31/78	☐ O/P ☐ RTD. CK. ☐ PREM. L/C 3/78

TO: NE MAT SE GL WN MAM BDI DIO BSSI

SOCIAL SECURITY ADMINISTRATION
1333 MACDONALD AVENUE
RICHMOND, CA 94801

F-3-b-255

DATE RECEIVED BY REV. OFF. ☐ CLAIM PENDING IN DO OR BO

RECEIVED IN DO BY: NAME: H Slay TITLE: S/R

DISTRICT OR BRANCH OFFICE: Richmond BO

DISTRICT OR BRANCH MANAGER: M JACKSON

FORM SSA-1395 (6-77)

RECEIPT FOR REMITTER - THANK YOU

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
RECEIPT AND TRANSMITTAL FORM

We acknowledge receipt of the following payment:

No. N 1028042

REMITTER

DATE	NAME OF BENEFICIARY	RSDI / SSI	SOCIAL SECURITY NO.	BIC/ARC
9/22/78	Bessie Wesley	☐ RSDI ☒ SSI	565-28-6142	

CK. OR M.O. NO.	CASH	AMOUNT	NAME OF REMITTER	DATE OF CHECK OR M.O.	REASON FOR PAYMENT
9,520,[illegible]		219.10	James Randolph	5/01/78	☒ O/P ☐ RTD. CK. ☐ PREM. L/C 3/78

TO: NE MAT SE GL WN MAM BDI DIO BSSI

SOCIAL SECURITY ADMINISTRATION
1333 MACDONALD AVENUE
RICHMOND, CA 94801

F-3-b-256

DATE RECEIVED BY REV. OFF. ☐ CLAIM PENDING IN DO OR BO

RECEIVED IN DO BY: NAME: H Slay TITLE: S/R

DISTRICT OR BRANCH OFFICE: Richmond BO

DISTRICT OR BRANCH MANAGER: M JACKSON

FORM SSA-1395 (6-77)

RECEIPT FOR REMITTER - THANK YOU

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
RECEIPT AND TRANSMITTAL FORM

We acknowledge receipt of the following payment:

No. N 1028043

REMITTER

DATE	NAME OF BENEFICIARY	RSDI / SSI	SOCIAL SECURITY NO.	BIC/ARC
9/22/78	Bessie Wesley	☐ RSDI ☒ SSI	565-28-6142	

CK. OR M.O. NO.	CASH	AMOUNT	NAME OF REMITTER	DATE OF CHECK OR M.O.	REASON FOR PAYMENT
9,227,797		219.10	James Randolph	6/1/78	☐ O/P ☐ RTD. CK. ☐ PREM. L/C 3/78

TO: NE MAT SE GL WN MAM BDI DIO BSSI

SOCIAL SECURITY ADMINISTRATION
1333 MACDONALD AVENUE
RICHMOND, CA. 94801

F-3-b-257

DATE RECEIVED BY REV. OFF. ☐ CLAIM PENDING IN DO OR BO

RECEIVED IN DO BY: NAME: H Slay TITLE: S/R

DISTRICT OR BRANCH OFFICE: Richmond BO

DISTRICT OR BRANCH MANAGER: M JACKSON

FORM SSA-1395 (6-77)

RECEIPT FOR REMITTER - THANK YOU

INSTRUCTIONS TO PERSON MAKING PAYMENT

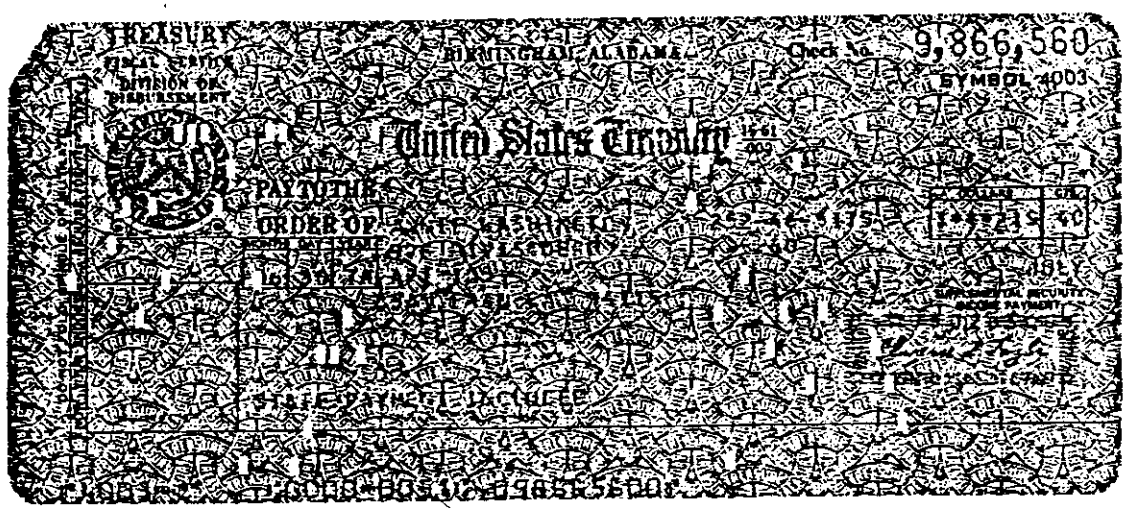
This receipt should be retained for your records. In the event of a question, the Social Security Claim number and Receipt number as shown on the reverse, should be furnished in order that the payment may be promptly identified.

INSTRUCTIONS TO PERSON MAKING PAYMENT

This receipt should be retained for your records. In the event of a question, the Social Security Claim number and Receipt number as shown on the reverse, should be furnished in order that the payment may be promptly identified.

INSTRUCTIONS TO PERSON MAKING PAYMENT

This receipt should be retained for your records. In the event of a question, the Social Security Claim number and Receipt number as shown on the reverse, should be furnished in order that the payment may be promptly identified.


TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT
BIRMINGHAM, ALABAMA
Check No. 9,866,560
SYMBOL 4003
United States Treasury
PAY TO THE ORDER OF
STATE PAYMENT INCLUDED

F-3-b-258

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

BIRMINGHAM, ALABAMA

Check No. 62,044,626
SYMBOL 3499

DO NOT FOLD, BENDING OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

United States Treasury 15-51 / 000

PAY TO THE ORDER OF ANNIE B WASHINGTON 252-46-5175

MONTH	DAY	YEAR
07	02	78

998 DIVISADERO 26 A 3
APT 105
SAN FRANCISCO CA 94115

DOLLARS	CTS.
$**0122	60

SOC SEC FOR JUN

F038

⑈34991⑈ ⑆0000⑈0051⑆ 620446266⑈

F-3-b-259

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

BIRMINGHAM, ALABAMA

Check No. 9,335,570
SYMBOL 3499

DO NOT FOLD, SPINDLE OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

United States Treasury

15-51
000

PAY TO THE ORDER OF ANNIE B WASHINGTON 252-46-5175
998 DIVISADERO 7C A 3
APT 105
SAN FRANCISCO CA 94115

MONTH	DAY	YEAR
08	03	78

DOLLARS	CTS
$***122	60

SOC SEC FOR JUL

039

REGIONAL DISBURSING OFFICER

⑈34991⑈ ⑆0000-0051⑆ 093355702⑈

F-3-b-260

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

BIRMINGHAM, ALABAMA

Chec No. 66,531,358
SYMBOL 3499

United States Treasury 15-51/000

DO NOT FOLD, BMHOLE OR MUTILATE
KNOW YOUR ENDORSER - REQUIRE IDENTIFICATION

PAY TO THE
ORDER OF ANNIE B WASHINGTON 252-46-5175

MONTH	DA	YR
09	01	78

998 DIVISADERO 58 A 3
APT 105
SAN FRANCISCO CA 94115

DOLLARS	CTS.
$***122	60

SOC SEC FOR AUG

041

⑈31,991⑈ ⑆0000⑈0051⑆ 665313583⑈

F-3-b-261

• mailed to
3330 Geary
5/13/75

F-3-b-262a

sent again 8/21/78

Memorandum or special commentary:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. R0506

SUPPLEMENT TO CLAIM OF PERSON OUTSIDE THE UNITED STATES

(To be completed by or on behalf of person who is, was, or will be outside the U.S.)

For social security purposes a person is outside the United States if he is physically outside the 50 States, the District of Columbia, Puerto Rico, Virgin Islands, Guam, and American Samoa.

1.	NAME OF WORKER ON WHOSE EARNINGS THIS CLAIM IS BASED Annie Bell Washington	WORKER'S SOCIAL SECURITY NUMBER 252-46-5175
2.	PRINT YOUR NAME *(If you are filing application on behalf of an incompetent adult, enter his or her name in this space and answer all subsequent questions on this questionnaire FOR him.)* Annie Bell Washington	YOUR U.S. SOCIAL SECURITY NUMBER 252-46-5175

CITIZENSHIP

3. (a) At the time of your birth, of what country (or countries) were you a citizen? — NAME OF COUNTRY *(or countries)*: U.S.

(b) Have you ever become a citizen of any country other than the country or countries shown in (a) above? ☐ Yes ☒ No
If "Yes," give the name of the country and explain how and when citizenship was acquired.

(c) Of what country (or countries) are you now a citizen? — NAME OF COUNTRY *(or countries)*: U.S.

(d) Do you have a valid passport? ☒ Yes ☐ No
If "Yes," give the following information:

DATE ISSUED	PASSPORT NUMBER	NAME OF GOVERNMENT THAT ISSUED PASSPORT
1-1-76	G036637	USA.

IF YOU ARE A U.S. CITIZEN, answer (e) and (f) below. If You are not a U.S. citizen, go on to question 4.

(e) After becoming a U.S. citizen, have you ever been employed by a foreign government either in a civilian or military capacity? ☐ Yes ☒ No
If "Yes," explain when and where.

(f) After becoming a U.S. citizen have you ever been convicted of any crime against the U.S.? ☐ Yes ☒ No
If "Yes," explain what crime(s), when, and where.

PHYSICAL PRESENCE IN THE U.S.

4. (a) Have you ever been physically present in the U.S. at any time? ☒ Yes ☐ No

(b) Are you now physically present in the U.S.? ☒ Yes ☐ No

If "Yes," enter the date you plan to leave the U.S. → MONTH, DAY, YEAR: 5/12/78

If "No," enter the date you left the U.S. → MONTH, DAY, YEAR:

(c) When do you plan to return to the U.S.? → MONTH, DAY, YEAR: over one year

(d) Did you enter or leave the U.S. at any time during the past 24 months? ☐ Yes ☒ No
If "Yes," give the following information concerning each of your arrivals and departures.

DATE OF ARRIVAL *(Month, day, year)*	DATE OF DEPARTURE *(Month, day, year)*	ADDRESSES OF PLACES YOU LIVED OR VISITED IN THE U.S.
F-3-h-262h		

EMPLOYMENT – SELF-EMPLOYMENT

A person is employed if he performs services for someone else and receives cash payment or other compensation for these services. This includes any part-time work or summer work by a child, or work by a child as an apprentice.

A person is self-employed if he has a business either by himself or with one or more partners. Some examples of self-employment are raising fruit, crops or livestock for sale, taking in sewing or laundry, providing services as a tutor, lawyer, or physician, etc. The amount of earnings (or loss) has no effect on whether the person is considered self-employed.

5. (a) Have you been employed or have you engaged in self-employment outside the U.S. during any of the past 24 months including the present month? ☐ Yes ☒ No

(b) If you are still in the U.S. will you engage in employment or self-employment outside the U.S.? ☐ Yes ☒ No

Give the following information about your employment or self-employment outside the U.S.

NAME AND ADDRESS OF EMPLOYER *(If self employed, show "self" and name and address of your trade or business.)*	TYPE OF BUSINESS	EMPLOYMENT OR SELF-EMPLOYMENT	
		DATE BEGAN OR WILL BEGIN	DATE ENDED *(If not ended, leave blank)*

CHANGES TO BE REPORTED PROMPTLY TO THE SOCIAL SECURITY ADMINISTRATION

Notify the Social Security Administration promptly if, while outside the U.S.:

(1) you become employed or self-employed while under age 72

(2) there is any change in your citizenship

(3) you go into a different country for more than 1 month.

6. (a) Do you agree to notify the Social Security Administration promptly when any of the above events occur? ☒ Yes ☐ No

FAILURE TO REPORT EMPLOYMENT OR SELF-EMPLOYMENT PROMPTLY AS AGREED MAY RESULT IN THE LOSS OF MONTHLY BENEFITS

(b) Do you also agree to return promptly any check for benefits received by you if you are not entitled to it? ☐ Yes ☐ No

MAILING ADDRESS

All social security checks are sent to the beneficiary's place of residence unless there is a valid reason for sending checks in care of another person or to another address.

7. (a) Give the complete address of residence abroad. *(The place outside the U.S. where you now live or intend to live.)*

Mission Village, N.W.R.
Guyana, South America

(b) Show the address to which checks are to be sent.

F-3-W-2L2C

C/O Mission Village
P.O. Box 893
Georgetown, Guyana, South America

(c) If you cannot receive checks at the place where you live, please explain why.

No reliable delivery to interior of country.

INFORMATION ABOUT THE WORKER NAMED IN ITEM 1. *(If you are the worker, give the information about yourself.)*

8. (a) Did the worker live in the U.S. for at least 10 years (i.e., make his temporary or permanent home in the U.S.)? ☒ Yes ☐ No

If "Yes," check the block which indicates the total time the worker lived in the U.S.:

☐ 10–19 Years ☐ 20–29 Years ☐ 30–39 Years

☐ 40–49 Years ☐ 50–59 Years ☒ 60–97 Years

and, indicate the address—or combination of addresses—which will describe 10 years of United States residence.

ADDRESS IN U.S. AT WHICH WORKER LIVED	DATE WORKER'S RESIDENCE BEGAN		DATE WORKER'S RESIDENCE ENDED	
	MONTH	YEAR	MONTH	YEAR
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

(If additional space is needed, use REMARKS SECTION on last page.)

(b) If the worker named in Item 1 is now deceased, did he die while in the military service of the U.S. or as a result of disease or injury incurred or aggravated in the military service of the U.S.? ☐ Yes ☐ No

If "Yes," explain.

N/A

(c) Name the country of which the worker is a citizen. *(If deceased, name the country of which he was a citizen at time of death.)* → NAME OF COUNTRY OR COUNTRIES: [illegible]

An explanation of the special circumstances that affect payment of benefits to beneficiaries outside the U.S. is given in the booklet SSA-609, "Your Social Security Check--While You're Outside the United States"

YOU SHOULD, HOWEVER, MAKE SPECIAL NOTE OF THE FOLLOWING:

I. Your benefits are not payable for any month in which:

A. You (while under age 72) engage in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month, OR

B. The worker (while under age 72) on whose account you are receiving benefits engages in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month.

A person is engaged in noncovered remunerative activity on 7 or more different calendar days a month, regardless of the amount of earnings and the number of hours worked on any particular day, if:

(1) he is carrying on a trade or business outside the United States as sole owner or partner on 7 or more different calendar days a month, and his net earnings from self-employment are not subject to United States social security taxes, OR

(2) he is employed (this includes stand-by employment) to perform services as an employee on 7 or more different calendar days a month and his wages are not subject to United States social security taxes, OR

(3) any combination of (1) and (2), amounting to 7 or more days a month.

II. If you are not a citizen or national of the United States, your benefits may not be payable for any month after you have been outside the United States for 6 consecutive calendar months. When your benefits are withheld for that reason, they cannot be resumed until you have been in the United States for a full calendar month.

(Aliens receiving benefits on the earnings record of a deported wage earner will not receive benefits if they are outside the United States any part of a month following his deportation.)

(Over)

F-3-V-262d

F-3-b-243a

For social security purposes a person is outside the United States if the person is physically outside the 50 States, the District of Columbia, Puerto Rico, Virgin Islands, Guam, and American Samoa.

1.	NAME OF WORKER ON WHOSE EARNINGS THIS CLAIM IS BASED Richard Wade	WORKER'S SOCIAL SECURITY NUMBER [redacted]
2.	PRINT YOUR NAME (If you are filing application on behalf of an incompetent adult, enter that person's name in this space and answer all subsequent questions on this questionnaire FOR that person.) Roberta Wade	YOUR U.S. SOCIAL SECURITY NUMBER 556-88-0220 DI

b6
b7C

CITIZENSHIP

3. (a) At the time of your birth, of what country (or countries) were you a citizen? — NAME OF COUNTRY (or countries): USA

(b) Have you ever become a citizen of any country other than the country or countries shown in (a) above? ☐ Yes ☐ No
If "Yes," give the name of the country and explain how and when citizenship was acquired.

(c) Of what country (or countries) are you now a citizen? → NAME OF COUNTRY (or countries): USA

(d) Do you have a valid passport? ☒ Yes ☐ No
If "Yes," give the following information:

DATE ISSUED	PASSPORT NUMBER	NAME OF GOVERNMENT THAT ISSUED PASSPORT
7/1977	[redacted]	USA

IF YOU ARE A U.S. CITIZEN, answer (e) and (f) below. If you are not a U.S. citizen, go on to question 4.

(e) After becoming a U.S. citizen, have you ever been employed by a foreign government either in a civilian or military capacity? ☐ Yes ☐ No
If "Yes," explain when and where.

(f) After becoming a U.S. citizen have you ever been convicted of any crime against the U.S.? ☐ Yes ☐ No
If "Yes," explain what crime(s), when, and where.

PHYSICAL PRESENCE IN THE U.S.

4. (a) Have you ever been physically present in the U.S. at any time? ☒ Yes ☐ No

(b) Are you now physically present in the U.S.? ☐ Yes ☐ No

If "Yes," enter the date you plan to leave the U.S. → MONTH, DAY, YEAR

If "No," enter the date you left the U.S. → MONTH, DAY, YEAR 3/9/75

(c) When do you plan to return to the U.S.? → MONTH, DAY, YEAR [illegible]

(d) Did you enter or leave the U.S. at any time during the past 24 months? ☒ Yes ☐ No
If "Yes," give the following information concerning each of your arrivals and departures.

DATE OF ARRIVAL (Month, day, year)	DATE OF DEPARTURE (Month, day, year)	ADDRESSES OF PLACES YOU LIVED OR VISITED IN THE U.S.
	3/9/75	516 Grove Ave, Richmond [illegible]

FORM SSA-21 F4 (9-77) (FORMERLY SSA-21) (Over)
PRIOR EDITIONS MAY BE USED UNTIL SUPPLY IS EXHAUSTED

EMPL[illegible] LF-E[illegible]

An employed person is one who performs servi[illegible] someone else and receives cash payment or other compensation for these services. This includes any part-time work or summer work by a child, or work by a child as an apprentice.

A self-employed person is one who has a business either alone or with one or more partners. Some examples of self-employment are raising fruit, crops or livestock for sale, taking in sewing or laundry, providing services as a tutor, lawyer, or physician, etc. The amount of earnings (or loss) has no effect on whether the person is considered self-employed.

5. (a) Have you been employed or have you engaged in self-employment outside the U.S. *during any of the past 24 months* including the present month? ☐ Yes ☒ No

(b) If you are still in the U.S., will you engage in employment or self-*employment outside the U.S.*? ☐ Yes ☒ No

Give the following information about your employment or self-employment outside the U.S.

NAME AND ADDRESS OF EMPLOYER *(If self-employed, show "self" and name and address of your trade or business.)*	TYPE OF BUSINESS	EMPLOYMENT OR SELF-EMPLOYMENT	
		DATE BEGAN OR WILL BEGIN	DATE ENDED *(If not ended, leave blank)*

CHANGES TO BE REPORTED PROMPTLY TO THE SOCIAL SECURITY ADMINISTRATION

Notify the Social Security Administration *promptly if*, while outside the U.S.:

(1) you become employed or self-employed while under age 72

(2) there is any change *in your citizenship*

(3) you go into a different country for more than 1 month.

6. (a) Do you agree to notify the Social Security *Administration promptly* when any of the above events occur? ☒ Yes ☐ No

FAILURE TO REPORT EMPLOYMENT OR SELF-EMPLOYMENT PROMPTLY AS AGREED MAY RESULT IN THE LOSS OF MONTHLY BENEFITS

(b) Do you also agree to return promptly any check for benefits received by you if you are not entitled to it? ☒ Yes ☐ No

MAILING ADDRESS

All social security checks are sent to the beneficiary's place of residence unless there is a valid reason for sending checks in care of another person or to another address.

7. (a) Give the complete address of residence abroad. *(The place outside the U.S. where you now live or intend to live.)*

Georgetown, Port Kaituma NWR, Guyana, So. America

(b) Show the address to which checks are to be sent.

PO Box 893 Georgetown, Guyana

(c) If you cannot receive checks at the place where you live, please explain why.

Reliability and Convenience

EMPLOYMENT - SELF-EMPLOYMENT

An employed person is one who performs services for someone else and receives cash payment or other compensation for these services. This includes any part-time work or summer work by a child, or work by a child as an apprentice.

A self-employed person is one who has a business either alone or with one or more partners. Some examples of self-employment are raising fruit, crops or livestock for sale, taking in sewing or laundry, providing services as a tutor, lawyer, or physician, etc. The amount of earnings (or loss) has no effect on whether the person is considered self-employed.

5. (a) Have you been employed or have you engaged in self-employment outside the U.S. during any of the past 24 months including the present month? ☐ Yes ☒ No

(b) If you are still in the U.S., will you engage in employment or self-employment outside the U.S.? ☐ Yes ☒ No

Give the following information about your employment or self-employment outside the U.S.

NAME AND ADDRESS OF EMPLOYER (If self-employed, show "self" and name and address of your trade or business.)	TYPE OF BUSINESS	EMPLOYMENT OR SELF-EMPLOYMENT	
		DATE BEGAN OR WILL BEGIN	DATE ENDED (If not ended, leave blank)

CHANGES TO BE REPORTED PROMPTLY TO THE SOCIAL SECURITY ADMINISTRATION

Notify the Social Security Administration promptly if, while outside the U.S.:

(1) you become employed or self-employed under age 72

(2) there is any change in your citizenship

(3) you go into a different country for more than 1 month.

6. (a) Do you agree to notify the Social Security Administration promptly when any of the above events occur? ☒ Yes ☐ No

FAILURE TO REPORT EMPLOYMENT OR SELF-EMPLOYMENT PROMPTLY AS AGREED MAY RESULT IN THE LOSS OF MONTHLY BENEFITS

(b) Do you also agree to return promptly any check for benefits received by you if you are not entitled to it? ☒ Yes ☐ No

MAILING ADDRESS

All social security checks are sent to the beneficiary's place of residence unless there is a valid reason for sending checks in care of another person or to another address.

7. (a) Give the complete address of residence abroad. *(The place outside the U.S. where you now live or intend to live.)*

Georgetown Port Kaituma R.R. Guyana, So. America

(b) Show the address to which checks are to be sent.

PO Box 893 Georgetown Guyana

(c) If you cannot receive checks at the place where you live, please explain why.

Reliability and Convenience

F-3-b-263b

[illegible] in the U.S.)?

If "Yes," check the block which indicates the total time the worker lived in the U.S.:

☐ 10–19 Years ☐ 20–29 Years ☐ 30–39 Years

☐ 40–49 Years ☐ 50–59 Years ☒ 60–97 Years

and, indicate the address--or combination of addresses--which will describe 10 years of United States residence.

ADDRESS IN U.S. AT WHICH WORKER LIVED	DATE WORKER'S RESIDENCE BEGAN		DATE WORKER'S RESIDENCE ENDED	
	MONTH	YEAR	MONTH	YEAR
516 Grove, Richmond	3	'76	3/9	'75
12808 E. Manning, Parlier, Calif		'55		'76

(If additional space is needed, use REMARKS SECTION on last page.)

(b) If the worker named in item 1 is now deceased, did the worker die while in the military service of the U.S. or as a result of disease or injury incurred or aggravated in the military service of the U.S.? ☐ Yes ☒ No

If "Yes," explain.

(c) Name the country of which the worker is a citizen. *(If deceased, name the country of which the worker was a citizen at time of death.)* → NAME OF COUNTRY OR COUNTRIES: U.S.A.

An explanation of the special circumstances that affect payment of benefits to beneficiaries outside the U.S. is given in the booklet titled, *"Your Social Security Check--While You're Outside the United States"*

YOU SHOULD, HOWEVER, MAKE SPECIAL NOTE OF THE FOLLOWING:

I. Your benefits are not payable for any month in which:

A. You (while under age 72) engage in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month, OR

B. The worker (while under age 72) on whose account you are receiving benefits engages in noncovered remunerative activity outside the United States on 7 or more different calendar days during a month.

A person is engaged in noncovered remunerative activity on 7 or more different calendar days a month, regardless of the amount of earnings and the number of hours worked on any particular day, if:

(1) The person is carrying on a trade or business outside the United States as sole owner or partner on 7 or more different calendar days a month, and these net earnings from self-employment are not subject to United States social security taxes, OR

(2) The person is employed (this includes stand-by employment) to perform services as an employee on 7 or more different calendar days a month and these wages are not subject to United States social security taxes, OR

(3) any combination of (1) and (2), amounting to 7 or more days a month.

II. If you are not a citizen or national of the United States, your benefits may not be payable for any month after you have been outside the United States for 6 consecutive calendar months. When your benefits are withheld for that reason, they cannot be *resumed until you have been in the United States for* a full calendar month.

(Aliens receiving benefits on the earnings record of a deported wage earner will not receive benefits if they are outside the United States any part of a month following the wage earner's deportation.)

(Over)

Social Security Medicare Notice

F-3-b-264

From: Bureau of Health Insurance

If you inquire, please include your Medicare Claim No. 525-40-9358B
Date JUL 05, 1978

ROBERTA WADE
MISSION VILLAGE
PO BOX 893
GEORGETOWN GUYANA
SO AMERICA 0 894

Your State Public Assistance Agency is no longer paying your Medicare MEDICAL INSURANCE premiums. The first month for which you are responsible for your medical insurance premium is

(Month and Year)

JUL 1978

If you are receiving social security payments, the premiums (including any you may owe for past months) will be deducted from future payments.

If you are not receiving social security payments, you will soon receive a bill for all premiums currently due. If you still owe premiums for any months before your State began paying them, the first month shown on your billing notice may be earlier than the date above. Do not pay anything until you receive this bill.

If you want to cancel your medical insurance coverage, notify your social security office immediately.

If you have any questions about this notice or your medical insurance protection, telephone or visit your social security office. Please take this notice with you if you visit a social security office.

YOUR NEXT SOCIAL SECURITY BENEFIT PAYMENT WILL BE IN THE AMOUNT OF $81.60 AND WILL BE RECEIVED AROUND AUG 03, 1978

Social Security Benefit Information

F-3-b-265

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

IRI-71734:PE

Richard & Roberta ~~Wage~~ WADE
% Mission Village
P.O. Box 893
Georgetown Guyana
SOUTH AMERICA

Date
July 25, 1978

Your Claim Number
[redacted] & B

b6
b7c

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

You should complete the enclosed form and return it to us immediately in the enclosed envelope which requires postage. If we do not receive the completed form within 6 months, benefit payments will be stopped until it is received.

Enclosure:
SSA-21s

Enclosures:
Form SSA-609
Form SSA-1425F

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOIUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 224

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
05/19/78	06/19/78
ACCOUNT NUMBER	
00-47381-2	
DESCRIPTION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	01	240 80	48 160	621 41	00	48 160

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	240 80	602				722 40	602
						722 40	
						ENDING BALANCE	

F-3-b-2662

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Bank of Montreal (California)

S.F
OFFICE

5-22-78
DATE

ADVICE OF MISPLACED CHECK

TO OUR DEPOSITOR: Dorothy Worley

ACCOUNT NUMBER 00-47381-2

ATTACHED IS THE MISPLACED CHECK (OR OTHER DEBIT ENTRY) THAT WAS PREVIOUSLY CHARGED TO YOUR ACCOUNT ON 5-17-78 IN THE AMOUNT OF $ 1,385.00

THIS ITEM WAS REPORTED TO YOU AT THE TIME YOU RECEIVED YOUR STATEMENT.

WE APPRECIATE YOUR PATIENCE IN THIS MATTER.

DATE OF THIS TRANSMITTAL _____

F-3-b-266b

Dino [signature]
AUTHORIZED SIGNATURE

TRANSMITTAL TO DEPOSITOR

F-3-b-266c NUMBER

April 25 1978

11-3
1210

PAY TO THE ORDER OF Cash $ 1,385.00

[illegible] DOLLARS and 00/100's

DOROTHY WORLEY

Bank of Montreal (California)
555 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

Dorothy Worley

⑆1210⑉0003⑆ 00 47381 2⑈ ⑈0000138500⑈

CHECKING ACCOUNT DEPOSIT TICKET

F-3-b-266d

Bank of Montreal (California)
555 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 6/7 1978

DOROTHY WORLEY
P.O. BOX 15186
SAN FRANCISCO, CALIF. 94115

CASH	
CHECKS	Sec. Sec. 240 80
TOTAL	
LESS CASH RECEIVED	
TOTAL ITEMS NET DEPOSIT	240 80

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

JUN 2 1978

11-3 Services 11-3

⑆1210⑉0003⑆ 00 47381 2⑈ ⑈0000024080⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

Bank of Montreal (California)

OFFICE DATE

ADVICE OF MISPLACED CHECK

ACCOUNT NUMBER

ATTACHED IS THE MISPLACED CHECK (OR OTHER DEBIT ENTRY) THAT WAS PREVIOUSLY CHARGED TO YOUR ACCOUNT

ON _____ IN THE AMOUNT OF $ _____

THIS ITEM WAS REPORTED TO YOU AT THE TIME YOU RECEIVED YOUR STATEMENT.

WE APPRECIATE YOUR PATIENCE IN THIS MATTER.

DATE OF THIS TRANSMITTAL

TRANSMITTAL TO DEPOSITOR

AUTHORIZED SIGNATURE

Dorothy Worley

Pay [illegible] Bank, Bai[illegible]

Barclays Bank Internat[illegible]

Prior end[illegible]

PAY ANY BANK — P.E.G. 1-12

103531424

MAY

0300 [illegible]

PAY ANY BANK P.E.G.
BK. OF MONTREAL
(CALIFORNIA)
SAN FRANCISCO CA.
11-3

JUN -2 [illegible]

F-3-b-267a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
06/19/78	07/19/78
ACCOUNT NUMBER	
00-47381-2	
DISPOSITION CODE: M	NUMBER OF ENCLOSURES: 1 / PAGE NO: 1

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	256.50	722.40	833.55	00	722.40

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	256.50	7/07				978.90	7/07
						978.90	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

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SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

F-3-b-267b

Bank of Montreal
(California)
333 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 7/7 19 78

CASH

CHECKS Soc. Sec. 256 50

TOTAL

NET DEPOSIT 256 50

BE SURE EACH ITEM IS PROPERLY ENDORSED

11-3
1210

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

JUL 7 19

11-3

⑆1210⑈0003⑆ 00 47⑈81 2⑈ ⑈0000025650⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 17161

PAY [illegible] P.E.G.
BK. [illegible] TREAL
([illegible]IA)
SAN [illegible] O CA.
11-3 11-3

JUL - 7 78

F-3-h-268a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
07/19/78	08/18/78
ACCOUNT NUMBER	
00-47381-2	
DISPOSITION CODE: M	NUMBER OF ENCLOSURES: 1	PAGE NO: 1

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits No.	Checks and Other Debits Amount	Deposits and Other Credits No.	Deposits and Other Credits Amount	LOW BALANCE	Average Balance	Service Charge	Beginning Balance
00	00	01	25650	97890	111570	00	97890

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	25650	803				123540	803
						123540	

ENDING BALANCE

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES No.	ADVANCES Amount	PAYMENTS No.	PAYMENTS Amount	FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
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- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

DP Deposit
DM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

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SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

F-3-b-268 b

Bank of Montreal
(California)
[illegible] CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 8/3 19 78

CASH	
CHECKS	Soc. Sec. 256 50
TOTAL	
LESS CASH RECEIVED	
TOTAL ITEMS	SET DEPOSIT 256 50

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

8 0 3 7

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

11-3 11-3

⑆1210⑈0003⑆ 00 47381 2⑈ ⑈0000025650⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 57824

PAY A[illegible] P.E.G.
EK. [illegible] TREAL
[illegible] NIA)
SA[illegible] CA.
11-[illegible] 11-3

AUG -3 78

F-3-b-269a

BANK OF MONTREAL
333 CALIFORNIA STREET
SAN FRANCISCO CALIFORNIA 94104
REFER YOUR INQUIRIES TO
THE ABOVE ADDRESS OR CALL
(415) 391-8060, EXT. 267

Bank of Montreal (California)

STATEMENT OF ACCOUNT

DATE OF PREVIOUS STATEMENT	DATE OF THIS STATEMENT
08/18/78	09/19/78
ACCOUNT NUMBER	
00-47381-2	
DISPOSITION CODE	NUMBER OF ENCLOSURES	PAGE NO
M	1	1

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CA 94115

USE REVERSE SIDE FOR BALANCING YOUR ACCOUNT.

CHECKING ACCOUNT ACTIVITY

Checks and Other Debits		Deposits and Other Credits		LOW BALANCE	Average Balance	Service Charge	Beginning Balance
No.	Amount	No.	Amount				
00	00	01	25650	123540	135563	00	123540

TRANSACTION DESCRIPTION	AMOUNT	DATE	TRANSACTION DESCRIPTION	AMOUNT	DATE	RUNNING BALANCE	DATE
DP	25650	905				149190	905
						149190	
						ENDING BALANCE	

STANDBY CREDIT ACCOUNT ACTIVITY

DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	ADVANCE/DEBIT	DATE	PAYMENT/CREDIT

STANDBY CREDIT ACCOUNT STATUS

Beginning Balance	Adjustments	ADVANCES		PAYMENTS		FINANCE CHARGE	CREDIT LIFE	Ending Balance	AVAILABLE CREDIT
		No.	Amount	No.	Amount				

CREDIT LINE	Balance on Which Finance Charge Was Computed	PERIODIC RATE	Days in Cycle	Annual Percentage Rate

SERVICES FOR YOUR CONVENIENCE

- COMMERCIAL LOANS
- INSTALMENT LOANS
- FREE POSTAGE ON MAIL DEPOSITS
- TRAVELERS CHECKS
- MONEY ORDERS
- SERIES "E" BONDS
- CHRISTMAS CLUB ACCOUNTS
- SAFE DEPOSIT
- CHECKING ACCOUNTS
- SAVING ACCOUNTS
- TIME CERTIFICATES OF DEPOSITS

AFFILIATES IN CANADA, EUROPE CENTRAL AND SOUTH AMERICA, JAPAN AND HONG KONG

OP Deposit
OM Debit Memo
DR Debit Reversal
CM Credit Memo
CR Credit Reversal
OC Overdraft Charge
CH NSF Charge
OD Account Overdrawn
SC Service Charge
XC XMAS Club Debit
LP Loan Payment
PA Standby Payment
SR Standby Payment Reversal
AA Standby Advance
SP Standby Payoff
ST Misc. Standby Credit
SD Misc. Standby Debit
* Sequence Break

Please check this statement promptly. Any errors, irregularities or omissions found therein should be reported within 15 days of delivery or mailing, otherwise it will be considered correct. Prompt notification of any change of address would be appreciated.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
[illegible] CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 9/4 19 78

11-3 Teller 2 11-

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

CASH	
CHECKS	Automatic deposit
TOTAL	
LESS CASH RECEIVED	
TOTAL ITEMS	NET DEPOSIT 256.50

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

F-3-b-269 b

⑆1210⑈0003⑆ 00 47381 2⑈ ⑈0000025650⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

0300 00938

PAY [illegible] E.G.
BK. [illegible] TREAL
[illegible] A)
SA[illegible] CA.
11-[illegible] 11-3

SEP -5 78

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
583 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 7/7 19 78

CASH		
CHECKS	Soc. Sec.	256 50
TOTAL		
LESS CASH RECEIVED		
TOTAL ITEMS NET DEPOSIT	256	50

[redacted]

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

F-3-b-270

16

⑆1210⑈0003⑆ 00 47381 2⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
583 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 8/3 19 78

CASH		
CHECKS	Soc. Sec.	256 50
TOTAL		
LESS CASH RECEIVED		
TOTAL ITEMS NET DEPOSIT	256	50

[redacted]

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

F-3-b-271

⑆1210⑈0003⑆ 00 47381 2⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT.

CHECKING ACCOUNT DEPOSIT TICKET

Bank of Montreal
(California)
583 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

DATE 9/4 19 78

CASH		
CHECKS	Christmas deposit	
TOTAL		
LESS CASH RECEIVED		
TOTAL ITEMS NET DEPOSIT	256	50

[redacted]

11-3
1210

BE SURE EACH ITEM IS PROPERLY ENDORSED

DOROTHY WORLEY
P.O. BOX 15156
SAN FRANCISCO, CALIF. 94115

do

F-3-b-272

⑆1210⑈0003⑆ 00 47381 2⑈

CHECKS AND OTHER ITEMS ARE RECEIVED FOR DEPOSIT SUBJECT TO THE TERMS AND CONDITIONS OF THIS BANK'S COLLECTION AGREEMENT

Dorothy Worley

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

375619

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
8/01/77	08-R-0381	ANNUITY	26.30
8/01/77	08-R-0381	C S PEN	61.72
8/01/77	08-R-0381	C O L	13.87
			F-3-b-273
			******101.89

DETACH BEFORE DEPOSITING CHECK

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

378410

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
9/01/77	09-R-0381	ANNUITY	26.30
9/01/77	09-R-0381	C O L	13.87
9/01/77	09-R-0381	C S PEN	61.72
			F-3-b-273
			******101.89

DETACH BEFORE DEPOSITING CHECK

Dorothy Worley

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

381467

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
10/01/77	10-R-0381	C S PEN	61.72
10/01/77	10-R-0381	ANNUITY	26.30
10/01/77	10-R-0381	C O L	13.87
			F-3-b-275
			******101.89

DETACH BEFORE DEPOSITING CHECK

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

319139

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
7/01/78	07-R-0381	C O L	18,96
7/01/78	07-R-0381	ANNUITY	26,30
7/01/78	07-R-0381	C $ PEN	61,72
	D. Waley		F-3-b-276
			******106,98

DETACH BEFORE DEPOSITING CHECK

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

322958

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
8/01/78	08-R-0381	C O L	18,96
8/01/78	08-R-0381	ANNUITY	26,30
8/01/78	08-R-0381	C $ PEN	61,72
		F-3-b-277	
			******106,98

DETACH BEFORE DEPOSITING CHECK

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

325414

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
9/01/78	09-R-0381	C O L	18,96
9/01/78	09-R-0381	C $ PEN	61,72
9/01/78	09-R-0381	ANNUITY	26,30
Dorothy Waley			F-3-b-278
			******106,98

DETACH BEFORE DEPOSITING CHECK

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

Dorothy Worley

328449

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
10/01/78	10-R-0381	C O L	18,96
10/01/78	10-R-0381	C S PEN	61,72
10/01/78	10-R-0381	ANNUITY	26,30

F-3-b-279

DETACH BEFORE DEPOSITING CHECK

******106,98

REMITTANCE ADVICE

COUNTY OF MENDOCINO
UKIAH, CALIFORNIA 95482

Dorothy Worley

331191

INVOICE DATE	REF. NO.	INVOICE NUMBER	INVOICE AMOUNT
11/01/78	11-R-0381	C O L	18,96
11/01/78	11-R-0381	C S PEN	61,72
11/01/78	11-R-0381	ANNUITY	26,30

DETACH BEFORE DEPOSITING CHECK

******106,98

Social Security Notice of Acknowledgement

F-3-b-281

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

IRI-71734:NR

Date
May 26, 1978

Your Claim Number
459-03-8056 HA

Theo Williams
% Mission Village
P.O. Box 893
Georgetown
GUYANA

☐ As you requested, we are enclosing your document(s).

☒ Receipt is acknowledged of: Your inquiry regarding nonreceipt of September 1977 through January 1978 check, dated February 13, 1978 for $1020.90.

☐ We have received your

The matter is receiving our attention, and we will be in touch with you about it as soon as possible.

☐ Your claim for benefits has been forwarded to our payment office. You will receive a determination as soon as possible.

☐ Your inquiry has been forwarded to our social security office in The people there will contact you shortly.

☒ Your letter has been forwarded to the Division of Disbursement, Treasury Department located in Philadelphia, PA . You will be notified by the treasury Department of the result of their investigation

Department of Health, Education, and Welfare
Social Security Administration

Form SSA-L526F (3-74)

Standard Form 1180-C (Rev. 8-75)
TREASURY FRM 7000 [illegible]

ADVICE OF REQUEST FOR STOP PAYMENT

(Forward to Payee or Claimant)

1. Date of Request	2. Reason	3. Amount	4. Date of Check	5. Symbol	6. Check Number
6/6/78	☒ Non-receipt ☐ Other: ☐ "x" if confirmation ☐ Lost ☐ Stolen ☐ "x" if correction	$1,020.90	2/13/78	3053	14,809,215

7. Payee's Name (enter only when not identical to the Claimant's name in Box 9)

F-3-b-282

8. Remarks (Including identification or reference)

[illegible]

9. Claimant of Check and Current Address

THEO WILLIAMS
% MISSION VILLAGE
P O BOX 893
GEORGETOWN - GUYANA
SOUTH AMERICA 894

DO NOT SEND

10. NOTICE TO PAYEE OR CLAIMANT:

Your claim is being handled by the Bureau of Government Financial Operations, Division of Check Claims, Washington, D.C. 20227. Please read and carefully observe the instructions on the other side of this form.

1180-117

(180-11)

TO PAYEE OR CLAIMANT:

1. IF YOU HAVE ALREADY CASHED THIS CHECK, THIS FORM SHOULD BE DESTROYED.

2. OTHERWISE, the United States Treasury will give active attention to your claim and advise you further as soon as possible. In the meantime, you should take no further action unless you have additional information to submit such as a change in your mailing address. Any additional information should be submitted over your signature and must accurately describe the check (items 3 through 6 on the other side). INITIAL PROCESSING OF YOUR CLAIM MAY TAKE UP TO SIX WEEKS FROM THE DATE OF THIS REQUEST (Item 1).

3. If this is not the check in question, *do not write* the Bureau of Government Financial Operations, Division of Check Claims, but *write to the Government Department or Agency* which authorized the issuance of the check(s) and give your identification number. You should furnish that office sufficient information to identify the check in question.

4. If you recover the ORIGINAL check before you receive a substitute check, YOU MUST SIGN AND DATE THIS FORM BELOW AND MAIL IT, BEFORE CASHING YOUR CHECK, to the Bureau of Government Financial Operations, Division of Check Claims, Stop Pay Branch, Washington, D.C. 20227. IF THE CHECK WAS ISSUED TO PAYEES JOINTLY, BOTH MUST SIGN BELOW.

DEPARTMENT OF THE TREASURY
BUREAU OF GOVERNMENT FINANCIAL OPERATIONS
DIVISION OF CHECK CLAIMS
STOP PAY BRANCH
WASHINGTON, D.C. 20227

I/We have recovered the check described in this form and will negotiate it. Please remove the stop payment.

Aug 16, 1974 [signature]
(Date) (Signature) (Signature)

Standard Form 1180 (Rev. 8-76)
4 TREASURY FRM 3000 0898 LwH

REQUEST FOR STOP PAYMENT

(Forward to Bureau of Government Financial Operations)

1. Date of Request	2. Reason	3. Amount	4. Date of Check	5. Symbol	6. Check Number
6/6/78	XX Non-receipt ☐ Other: ☐ "x" if confirmation ☐ Lost ☐ Stolen ☐ "x" if correction	$1,020.90	2/13/78	3053	14,889,215

7. Payee's Name (enter only when not identical to the claimant's name in Box 9)

8. Remarks (Including identification or reference)

459 03 8056 A

F-3-b-283a

9. Claimant of Check and Current Address

THEO WILLIAMS
Z MISSION VILLAGE
P O BOX 893
GEORGETOWN - GUYANA
SOUTH AMERICA 894

11. (RESERVED FOR BSFO)

STOPPED JUN 6 1978

NOT PAID | REM'L AUTH'D BY

BOND/APPL/LETTER

Intercepted

TO | ON

1208 JUN 16 1978

1133

MISC.

OTHER

10. To: BUREAU OF GOVERNMENT FINANCIAL OPERATIONS, DIVISION OF CHECK CLAIMS, STOP PAY BRANCH, WASHINGTON, D.C. 20227

From: Disbursing Officer

I CERTIFY that the above check description is correct and that nothing in my records indicates that the payee is not entitled to its proceeds UNLESS OTHERWISE STATED UNDER "REMARKS."

Check Claims Division

1180-117

DIVISION OF
CHECK CLAIMS
REFER TO DCC:

DEPARTMENT OF THE TREASURY

FISCAL SERVICE

BUREAU OF GOVERNMENT FINANCIAL OPERATIONS
WASHINGTON, D.C. 20227

You have inquired about a U. S. Treasury check. A copy of that check is attached. Examine the endorsement on the back of the check copy.

IF YOU DID NOT SIGN THE CHECK OR AUTHORIZE ANYONE TO SIGN IT FOR YOU, AND YOU DID NOT BENEFIT FROM IT, PLEASE COMPLETE THE ENCLOSED CLAIM FORM(S) AS FOLLOWS:

1. **PRINT** symbol, check number, date, amount and payee's name shown on the attached check copy in the spaces provided.
2. **ANSWER ALL** questions on the front and back.
3. **SIGN** the claim.
4. Have **WITNESSES SIGN** also.
5. **RETURN** the claim **AND** the check copy to:

   Bureau of Government Financial Operations
   Division of Check Claims
   401 14th Street, S. W.
   Washington, D. C. 20227

IF THE CHECK BEARS only the stamped endorsement of your bank, we suggest that you show the check copy to a teller in that bank in order to receive credit.

IF YOU DO NOT WISH TO MAKE A CLAIM, it is not necessary to return anything.

IF YOU MAKE A CLAIM we will handle your case as quickly as possible. The United States Secret Service will investigate if you allege forgery or unauthorized endorsement. Send us any change in your address. Any other correspondence will only delay processing your claim.

IF YOU SIGNED THE CHECK and then lost it or had it stolen, we will not be able to assist you in regaining the proceeds of the check. We suggest that in the future you do not sign your check until you are actually cashing it.

DIRECTOR, DIVISION OF CHECK CLAIMS

I-3-b-283b

TFS FORM 1133S 1-76 FORMERLY TUS FORM 1133S, 12-73, WHICH MAY BE USED.

Standard Form 1180-B (Rev. 5-70)
TREASURY FRM 7000

ADVICE OF REQUEST FOR STOP PAYMENT

(Forward to Bureau of Government Financial Operations)

1. Date of Request	2. Reason	3. Amount of Check	4. Date of Check	5. Symbol	6. Check Number
[illegible]	Nonreceipt ☐ Stolen ☐ Other	$1,020.96	3/13/78	3053	14,009,215

7. Payee's name and address, when not identical to the claimant's name ...

8. Remarks ...

9. Claimant of check and current address ...

[illegible]

10. NOTICE TO PAYEE OR CLAIMANT:

PLEASE READ AND NOTE CAREFULLY THE INFORMATION ON THE OTHER SIDE OF THIS FORM

BUREAU OF GOVERNMENT FINANCIAL OPERATIONS

F-3-6-283C

1180-117

TREASURY
FISCAL SERVICE
DIVISION OF DISBURSEMENT

791 577541E

Check No. [illegible]

SYMBOL [illegible]

United States Treasury

PAY TO THE ORDER OF THEO WILLIAMS
C/O MISSION VILLAGE
PO BOX 553
GEORGETOWN
GUYANA 89

02 13 78

459-03-8056

$001020 96

SOC SEC INS

[redacted]

[redacted]

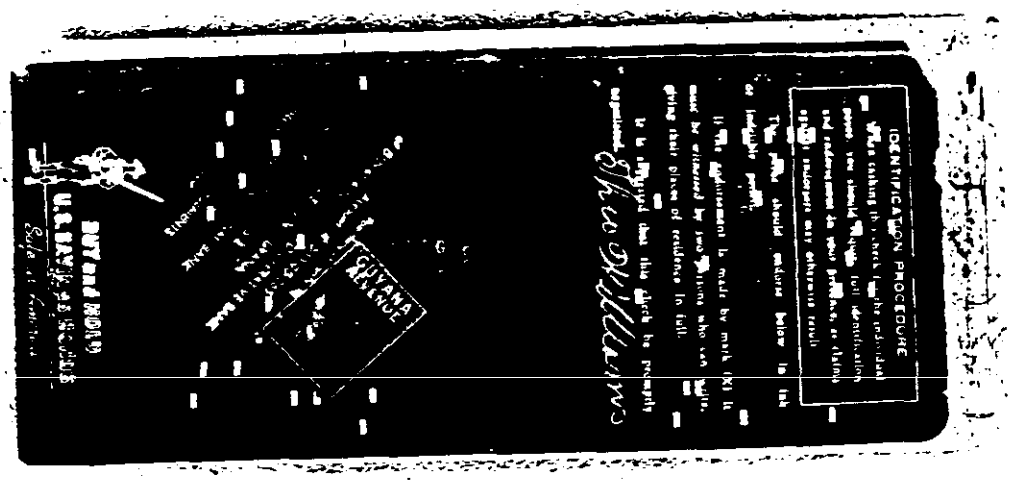
TO PAYEE OR CLAIMANT:

Attached is a copy of the Government check [illegible]

1. ☐ Your claim for the proceeds of the check cannot be allowed because it has been paid apparently bearing your genuine endorsement.
2. ☐ The check bears the endorsement of [illegible] and it is assumed that the check copy will enable you to effect an adjustment.
3. ☐ Since the check was lost or stolen bearing your genuine endorsement, the United States Treasury cannot recover the amount from the endorsing bank for your benefit. It is suggested that you do not endorse a check until you are actually cashing it.
4. ☐ The check has been paid bearing a bank endorsement indicating you have received credit for its amount. If necessary, the check copy will assist you in obtaining an [illegible]
5. ☐ If the check appears to have been [illegible] or unauthorized endorsement, the check copy should be returned to Bureau of Government Financial Operations, Division of Check Claims, Washington, D.C. 20227 at once with a factual statement [illegible] of the payee or other claimant.

NOTICE: IF THIS CHECK IS NOT A COPY OF THE CHECK IN QUESTION, DO NOT WRITE THE BUREAU OF GOVERNMENT FINANCIAL OPERATIONS, DIVISION OF CHECK CLAIMS, BUT WRITE TO THE GOVERNMENT DEPARTMENT OR AGENCY WHICH AUTHORIZED THE ISSUANCE OF THE CHECK(S) AND GIVE YOUR IDENTIFICATION NUMBER. YOU SHOULD FURNISH THAT OFFICE SUFFICIENT INFORMATION TO IDENTIFY THE CHECK IN QUESTION.

ADVICE OF REQUEST FOR STOP PAYMENT



CLAIM AGAINST THE UNITED STATES
FOR THE PROCEEDS OF A GOVERNMENT CHECK OR CHECKS

JUL 11 1978

The Social Security Account Number, if applicable, and other information requested is required under the authority of 31 USC 71, with delegation of authority from the Comptroller General of the U.S., and Executive Order 9397, dated November 22, 1943. This information is for routine use in processing a claim for a Government check(s). If all information is not furnished the processing of the claim may be delayed.

To EXPEDITE processing of your claim, please complete, sign, and return this form within (5) days.

I am the payee and owner of the following-described check and, having examined a photocopy of the check and the endorsement thereon, declare that I did not in any manner participate in any part of the proceeds and I hereby make claim for the amount of the check. In support of this claim I make the following statements which I declare to be true to the best of my knowledge and belief:

SYMBOL	CHECK NO.	DATE	AMOUNT
PAYEE:			

	(Answer fully)
1. Was the check received, or did you ever see it?	
2. Did you endorse this check?	
3. Was the endorsement of your name on the check made with your consent or by agreement or understanding with anyone?	
4. State the purpose for which the check was issued.	
5. Give your identification number relative to the check, such as Social Security, Military Service, Veterans compensation, etc.	

WARNING.-Title 18, Sec. 287, U.S. Code: "Whoever makes or presents to any person or officer in the civil, military, or naval service of the United States, or to any department or agency thereof, any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be fined not more than $10,000 or imprisoned not more than five years, or both."

Signature of Co-Payee, if applicable: .....

TWO Witnesses to signature(s) required:

Signature of Witness: .....

Address of Witness: .....

Signature of Witness: .....

Address of Witness: .....

F-3-b-283e

Signature of Payee: .....

Address: .....

City & State: .....

Date Signed: .....

TFS FORM 10-75 1133C FORMERLY GFO FORM 1133C, REV. 4-74 WHICH MAY BE USED.

DEPARTMENT OF THE TREASURY - FISCAL SERVICE
BUREAU OF GOVERNMENT FINANCIAL OPERATIONS

NOTICE

The following information is for investigative purposes and
YOU MUST ANSWER ALL QUESTIONS FULLY

6. If your present name differs from that on the FACE of the check, explain the reason therefor.	
7. If an address is given on the face of the check, state whether you	(a) ever lived at such address ☐ YES ☐ NO (b) ever received your mail there ☐ YES ☐ NO
8. What was your mailing address on the date of the check?	Did you also live at this address? ☐ YES ☐ NO
9. If you had changed your address, did you so advise a Government Office?	☐ YES ☐ NO Which one?

10. What are the names, addresses, and relationship to you of the persons who resided at the address shown on check?

NAME	ADDRESS	RELATIONSHIP

11. Do you have any reason to believe that the check was endorsed, or that the proceeds were received by any person whose name is listed in the answer to No. 10 above.	☐ YES ☐ NO ☐ YES ☐ NO by any associate ☐ YES ☐ NO by any member of your family
(If your answer to any of the above questions is "YES", give name and address of person suspected.)	
12. Were you ever in the establishment where the check was cashed?	☐ YES ☐ NO Are you known there? ☐ YES ☐ NO
13. Where did you usually cash your checks at the time the above-described check was cashed?	
14. Give any other facts known to you regarding the forging or cashing of the check.	
15. Give the name and address of your present place of employment.	Telephone No.
16. Print or type your correct name and mailing address.	ZIP Code:

17. *Signature of Payee:* . . . . . *Signature of Co-Payee, if applicable:* . . . . . .

Residence Address: . . . . . .

City & State: . . . . . *Zip Code:* . . . . . .

Telephone Number: . . . . . .

F-3-b-284

VETERANS ADMINISTRATION

941 N CAPITOL ST NE
WASHINGTON DC 20421

JULY 31, 1978

IN REPLY REFER TO: 21/24

THEO WILLIAMS JR
PO BOX 893
GEORGETOWN GUYANA
SOUTH AMERICA
894

FILE NUMBER:
C- 5 125 823
T WILLI

YOUR AWARD HAS BEEN AMENDED TO PROVIDE FOR PAYMENT AS FOLLOWS.

MONTHLY RATE	EFFECTIVE DATE	REASON
$75.24	01/01/78	INCOME CHANGE

THIS ACTION RESULTED IN AN ADJUSTMENT DUE YOU OF $25.48.

VETERANS ADMINISTRATION

IMPORTANT – SEE REVERSE FOR PROCEDURAL AND APPELLATE RIGHTS
KEEP THIS LETTER FOR FUTURE REFERENCE

VA FORM DEC 1975 21 – 8332a-2

F-3-b-285

VETERANS ADMINISTRATION

941 N CAPITOL ST NE
WASHINGTON DC 20421

AUGUST 30, 1978

IN REPLY REFER TO 21/24

THEO WILLIAMS JR
PO BOX 893
GEORGETOWN GUYANA
SOUTH AMERICA
894

FILE NUMBER
C- 5 125 823
T WILLI

YOUR AWARD HAS BEEN AMENDED TO PROVIDE FOR PAYMENT AS FOLLOWS.

MONTHLY RATE	EFFECTIVE DATE	REASON
$75.24	01/01/76	INCOME CHANGE

THANK YOU.
VETERANS ADMINISTRATION

IMPORTANT — SEE REVERSE FOR PROCEDURAL AND APPELLATE RIGHTS

KEEP THIS LETTER FOR FUTURE REFERENCE

VA FORM DEC 1975 21 — 8332a-2

Social Security Benefit Information

F-3-b-286

From: Bureau of Retirement and Survivors Insurance
Division of International Operations
P.O. Box 1756, Baltimore, Maryland 21203, U.S.A.

Carol Young
PO Box 893
Georgetown
GUYANA

Date
October 9, 1978

Your Claim Number
[redacted]

b6
b7c

We have changed your address in our records, as you requested. Please let us know if your address is not complete or if you move again. Your checks will now be delivered somewhat later than usual because of the distance and the special handling involved.

While you are outside the United States, you may not be eligible for your benefits for any month you are under 72 and work or engage in any business in any part of 7 or more days. This is true regardless of how little you earn or how few hours you work during those 7 days.

The enclosed booklet gives more information about how work and other matters affect your right to receive benefits. We are also enclosing a postcard which you may use to report any of the events described in the booklet.

Any check you receive for which you are not eligible for payment should be returned to the Treasury Department, Director, Disbursing Center, P.O. Box 7407, Philadelphia, Pennsylvania 19101, U.S.A.

Your benefits have been resumed effective January 1978 at the monthly benefit rate of $161.90 and the amendments to the Social Security Act increased your monthly benefit to $172.50 effective June 1978. This check for $1420.50 covers benefits due you through September 1978. The amount of $79.00 has been deducted for Medical Insurance premiums for February 1978 through June 1978 at the rate of $7.70, and $8.20, July 1978 through October 1978.

Enclosures:
Form SSA-609
Form SSA-1425F

If you believe this determination is not correct, you may request that your claim be reexamined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office. Residents of the United States, Canada, and Mexico may call, write, or visit any social security office. If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice. If additional evidence is available, you should submit it with your request.

1. Work Outside the U.S.

If you work or own a business outside the U.S.—and you're still under 72—you may not be eligible for social security benefit checks. It's in your best interest to report all employment even though you don't think your work or business will affect your social security checks. By employment, we mean you have a job—even a part-time job—or you are working for yourself as a farmer, writer, sales representative, artisan, etc. Any work as an apprentice must also be reported. If you own a business, you should notify us even if you do not work in the business or receive any income from it.

Send your notice to us by airmail. If your work is not covered by the United States social security program, the general rule is that you can't get a check for any month you've worked or owned a business on any part of 7 or more days while you're under 72. If you can't get a check, then neither can any of your dependents. If your work is covered by the United States social security program, the same annual retirement test will be applied as is applied to beneficiaries in the United States. If you want a fuller explanation, see the people at your nearest U.S. Foreign Service post.

We cannot explain in detail how your checks may be affected by your work. However, upon receipt of your work notice, we will send you a form to fill out. The information you submit on the form will help us decide whether your work or business will affect your checks. You will receive a decision in writing.

2. If You Are Enrolled For Medical Insurance Coverage This Information About Medical Insurance Premiums Applies to You

a. *If monthly social security benefits are being paid to you now—*

Your next payment will be adjusted for any premiums you now owe or excess premiums you have paid in advance. After that, 1 month's premium will be withheld from your benefit payment each month.

b. *If monthly social security benefits are not being paid to you now—*

You will be billed for the premiums to pay for your medical insurance. The first bill you receive will cover all premiums due at that time. Further bills will cover the premiums due in advance for a 3-month period.

Each bill will show the months covered and will be sent to you shortly before the payment is due.

c. *Medicare outside the U.S.*

Generally, no Medicare services are provided outside the U.S. The only exceptions are inpatient services provided in Canadian or Mexican hospitals, in limited situations involving emergencies occurring inside the U.S. or while traveling through Canada between Alaska and another State, or where the foreign hospital is nearer the beneficiary's residence in the U.S. than the nearest U.S. hospital which can provide the care needed. There is a monthly premium charged for Supplementary Medical Insurance. Since you may cancel your Supplementary Medical Insurance at any time, and thereby eliminate payment of the premium, you should consider whether you wish to retain your Supplementary Medical Insurance.

You may cancel your medical insurance at any time. Residents of the United States, Canada, and Mexico may call, write, or visit any social security office for assistance. If you live in the Philippines, you should contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration, at the address shown on the reverse side of this notice. The cancellation is not effective until the third month after the month in which it is filed.

If you cancel your medical insurance, you can re-enroll at a later day, but only once. In that case, the premium is increased by ten percent for each full year that you could have been enrolled but were not.

3. Information About Overpayments

If you cannot afford to refund the full overpayment at one time or have your full payment withheld until the overpayment is recovered, get in touch with any social security office to see about repayment by installments or having a smaller amount withheld from your social security payments over a longer period of time. If you live in the United States, Canada, or Mexico, you can get in touch with any social security office. If you live in the Philippines, you can contact the United States Veterans Administration Regional Office, SSA Section, 1131 Roxas Boulevard, Manila. All other persons may contact the nearest United States Foreign Service post or write directly to the Social Security Administration at the address shown on the reverse side of this notice.

Any overpayment must be withheld from benefits or paid back unless both the following statements are true:

a. The overpayment wasn't your fault in any way and you accepted the payment(s) because you thought they were correctly paid to you, and

b. You couldn't meet your necessary living expenses if you had to pay back the overpayment or have it withheld from your social security payments, or if it would be unfair for some other reason.

If you believe you were without fault and that you should not have to repay the money, you should write to us at the address shown on the reverse side of this notice. We shall need a statement of your assets, monthly income, and expenses to help decide whether repayment would cause you financial hardship.

COUNTY OF LOS ANGELES

STATEMENT OF ALLOWANCE AND DEDUCTIONS

TO BE RETAINED BY RETIRED MEMBER

	MEMBER NO.	ISSUE DATE	WARRANT NO.	NORMAL ALLOWANCE	COST OF LIVING	TOTAL ALLOWANCE	MISC. DEDUCTIONS	NET PAYMENT	YTD ALLOWANCE
2	9768	83177	148666	20914	7730	28644	2068	26576	226650

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS

										YTD Federal Tax
73	205368	15								0000000

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS

										YTD State Tax
										0000000

CODES FOR MISCELLANEOUS DEDUCTIONS

50 Courts & Records C.U.	57 LAC-USC Med. Cen. C.U.	64 Co. Employees Association	71 Bus Loan
51 Credit Union No. 11	58 Public Services C.U.	65 Sheriffs Relief Assoc.	72 Blue Cross
52 Fiscal Employees C.U.	59 Harbor Hospital C.U.	66 Local 1014 (Firefighters Association)	73 Occidental
53 Firemen & Agric. C.U.	60 Olive View C.U.	67 P.O. Protective Association	74 Federal Tax Withheld
54 Rancho Los Amigos C.U.	61 Long Beach Gen. Hosp. C.U.	68 Alumni Association	75 State Tax Withheld
55 Ingleside C.U.	62 John Wesley Co. Hosp. C.U.	69 Mathews	76 Local 1014 Dues/Life Insurance
56 Chic Center C.U.	63 Flood Control Dist. C.U.	70 Kaiser	77 Dental/Vision Insurance

NOT NEGOTIABLE

F-3-a-1

Anthony
1057 Citrus Avenue
Chico, CA 95926

S. Woodall
P.O. Box 10215
Stanford, CA 94305
U.S.A.

upee of [illegible]
d called to ask.
? to say hello and
[illegible]

[redacted]

MEMBER NO. 1-15927-A Geraldine Bailey

DUPLICATE

RETIREMENT WARRANT FOR THE MONTH OF May, 1977.

TOTAL $364.84

ZH:MB;nn

F-3-a-2

[redacted]

[redacted]

E. J. MARTIN
RETIREMENT SYSTEMS MANAGER

COUNTY OF LOS ANGELES

OFFICE OF THE TREASURER

H. B. ALVORD

RECEIVED
JUL 25 1977
VOUL. NO.

RETIREMENT DIVISION
440 HALL OF ADMINISTRATION
LOS ANGELES, CALIFORNIA 90012
(213) 974-2141

July 19, 1977.

Geraldine H. Bailey
P. O. Box 15156
San Francisco, CA. 94115

In response to your request of July 19, 1977, enclosed is a duplicate warrant for the month of May, 1977, and an affidavit which requires your signature and immediate return to our office.

Your original warrant is now void. Should you receive Warrant No. 085624, issued on May 31, 1977, please return it to our office, as it is no longer payable.

For your convenience, an envelope is enclosed.

Very truly yours,

H. B. ALVORD, Secretary
Board of Retirement

E. C. Morris

By
E. C. Morris, Chief
Retirement Services Division

HBA:ECM:
MB:zh

Enclosure

F-3-a-3

PG and E PLEASE DETACH REFUND NO. 161300

ACCOUNT NUMBER

TRG2954373

Geraldine Bailey

OCTOBER 18 1977

OVERPAYMENT ON CLOSED ACCOUNT $**********4.54

998 DIVISADERO ST #203
SN FRANCISCO CA 94115

F-3-a-4

61-7117
10-74

PG and E PLEASE DETACH REFUND NO. 161301

ACCOUNT NUMBER

TRG2954373

Geraldine Bailey

OCTOBER 18 1977

DEPOSIT LESS CLOSING BILL $*********21.21

998 DIVISADERO ST #203
SN FRANCISCO CA 94115

F-3-a-5

61-7117
10-74

GERALDINE BAILEY

COUNTY OF LOS ANGELES

STATEMENT OF ALLOWANCE AND DEDUCTIONS

TO BE RETAINED BY RETIRED MEMBER

	MEMBER NO.	ISSUE DATE	WARRANT NO.	NORMAL ALLOWANCE	COST OF LIVING	TOTAL ALLOWANCE	MISC. DEDUCTIONS	NET PAYMENT	YTD ALLOWANCE
1	15927	73177	124364	32415	4069	36484		36484	252199

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS — YTD Federal Tax 0000000

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS — YTD State Tax 0000000

CODES FOR MISCELLANEOUS DEDUCTIONS

50 Courts & Records C.U.
51 Credit Union No. 11
52 Fiscal Employees C.U.
53 Firemen & Agric. C.U.
54 Rancho Los Amigos C.U.
55 Engineers C.U.
56 Civic Center C.U.
57 LAC-USC Med. Cntr. C.U.
58 Public Services C.U.
59 Harbor Hospital C.U.
60 Olive View C.U.
61 Long Beach Gen. Hosp. C.U.
62 John Wesley Co. Hosp. C.U.
63 Flood Control Dist. C.U.
64 Co. Employees Association
65 Sheriffs Relief Assoc.
66 Local 1014 (Firefighters Association)
67 P.O. Protective Association
68 Albino Association
69 Medicare
70 Kaiser
71 Bass Lake
72 Blue Cross
73 Occidental
74 Federal Tax Withheld
75 State Tax Withheld
76 Local 1014 Disability Insurance
77 Dental/Vision Insurance

NOT NEGOTIABLE

F-3-a-6

COUNTY OF LOS ANGELES

STATEMENT OF ALLOWANCE AND DEDUCTIONS

TO BE RETAINED BY RETIRED MEMBER

	MEMBER NO.	ISSUE DATE	WARRANT NO.	NORMAL ALLOWANCE	COST OF LIVING	TOTAL ALLOWANCE	MISC. DEDUCTIONS	NET PAYMENT	YTD ALLOWANCE
1	15927	031177	143707	3241.5	406.9	364.84		364.84	2886.63

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS

YTD Federal Tax 000000

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS

YTD State Tax 000000

CODES FOR MISCELLANEOUS DEDUCTIONS

NOT NEGOTIABLE

F-3-a-7

COUNTY OF LOS ANGELES

STATEMENT OF ALLOWANCE AND DEDUCTIONS

TO BE RETAINED BY RETIRED MEMBER

	MEMBER NO.	ISSUE DATE	WARRANT NO.	NORMAL ALLOWANCE	COST OF LIVING	TOTAL ALLOWANCE	MISC. DEDUCTIONS	NET PAYMENT	YTD ALLOWANCE
1	15927	103177	182643	3241.5	406.9	364.84		364.84	3616.51

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS

YTD Federal Tax 000000

MISCELLANEOUS DEDUCTION CODES AND AMOUNTS

YTD State Tax 000000

CODES FOR MISCELLANEOUS DEDUCTIONS

NOT NEGOTIABLE

F-3-a-8

DENNY'S, INC.

PROFIT SHARING AND SAVINGS PLAN

The attached check represents the balance of your account in the Denny's, Inc. Profit Sharing and Savings Plan.

If you should become an employee of Denny's, Inc. in the future, please be sure to contact the Profit Sharing Administrator at the La Mirada headquarters regarding your eligibility to participate again in the Profit Sharing and Savings Plan.

F-3-a-9

Pacific Telephone

This Is Your Record - Please Detach

OCT 31 1977 **S804-0243**

Code	Account Number	Public Tel Collections (less U.S. tax)	Deposit Amount	Interest	From Mo	From Day	To Mo	To Day	Amount
3	922 9012 566								23 88

The Attached Draft is in Payment of

CODE
1 Refund of Advance Payment
2 Refund of Deposit
3 Refund Of Overpayment on Final Bill
4 Commission on Public Telephone Collections
5 Credit Balance on Final Bill
6 Other (Detail Enclosed)

Elaine Bell

This is not a check - **DO NOT CASH**

F-3-a-10

FOWLER & BALL
ATTORNEYS AT LAW
150 NORTH PINE STREET
UKIAH, CALIFORNIA 95482

ROBERT A. FOWLER
JANE M. BALL

MAILING ADDRESS:
P. O. BOX 540
TELEPHONE:
(707) 462-1429
IN REPLY REFER TO

December 6, 1977

Mrs. Edith Bogue
Post Office Box 192
Redwood Valley, California 95470

Dear Edith:

Enclosed is my check in the amount of $104.15 for the hours you worked in July together with your wage statement for that period.

Yours truly,

Bob

Robert A. Fowler

RAF:dp

Enclosure

P.S. Stop by & see us if you visit Mendocino County.

F-3-a-11

EMPLOYER
Fowler & Ball

Emp. No. ______ Pay For Period Ending July 31, 1977

Employee's Name Edith Bogue

Date Hired ______ Date Discharged ______

Place Of Employment ______ Schedule Hours This Period ______

DAYS AND HOURS WORKED	SUN.	MON.	TUES.	WED.	THUR.	FRI.	SAT.	TOTAL DAYS	TOTAL HOURS	RATE PER HR.		
HOURS									29.5	3.75	110	62
OVER TIME												

SALARY (If paid on Fixed Weekly or Monthly Basis)			
REMUNERATION OTHER THAN CASH (Room, Board, Tips, etc.)			
GROSS EARNINGS		110	62
DEDUCTIONS			
% WITHHOLDING TAX			
% STATE DISABILITY INSURANCE			
% FED. INS. CONTRIBUTION ACT	647		
% STATE WITHHOLDING TAX			
TOTAL DEDUCTIONS			647
NET EARNINGS		104	15
LESS: REMUNERATION OTHER THAN CASH			
☐ BY CASH ☑ BY CHECK NO. 1942 — NET PAY THIS PERIOD		104	15

I HEREBY CERTIFY THAT THE TIME SHOWN ABOVE IS CORRECT

Employee Sign Here ______

4H 417 Rediform

F-3-a-12

Bookkeeping Services

COMMERCE, CLEARING, HOUSE, INC.

CHICAGO, ILLINOIS

18-4917-00 09/23/77
A REMITTANCE RECENTLY RECEIVED FROM YOU RESULTS IN A NET
CREDIT BALANCE TO YOUR ACCOUNT.
ENCLOSED IS OUR REFUND CHECK IN THE AMOUNT OF $***22.77

COMMERCE, CLEARING, HOUSE, INC.

DETACH BEFORE DEPOSITING

F-3-a-13

QUALITY CARE HEALTH CENTERS, INC.

		department no.		employee name	statement of earnings
9138	50	1 1 2	3035	BREIDENBACH, AVIS	

pay period from	to	check no.	social security no.
07-01-77	07-15-77	31740351	[redacted]

earnings description	units	rate	amount	voluntary deductions description	amount	ytd bal.
REGULAR	8550		22230			

NOT NEGOTIABLE

not negotiable

total: earnings $ 222.30 deductions

current and year to date

gross	fit w/h	fica	sdi	sit w/h	city	other	net pay
22230	1366	1300	222	195			$ 191.47
220887	16689	12920	2209	972			

UCB a service of united california bank

F-3-a-14

66
07C

b6
b7c

QUALITY CARE HEALTH CENTERS, INC.

9138	50	1	1	3035	BREIDENBACH, AVIS

pay period: from 07-16-77 to 07-31-77 | check no. 31922750 [redacted]

earnings: description	units	rate	amount	voluntary deductions: description	amount	yrd bal.
REGULAR	39.50		102.70	UNION DUES	6.00	36.00
HOLIDAY	8.00	3.90	31.20			

NOT NEGOTIABLE

total: earnings $ 133.90 deductions $ 6.00

current and year to date

gross	fit w/h	fica	sdi	sit w/h	city	other	net pay
133.90	40	7.83	1.34	1			$ 118.33
2342.77	167.29	137.03	23.43	9.72			

statement of earnings

not negotiable

UCB a service of united california bank

F-3-a-15

[redacted] [redacted]

51 GOODWILL INDUSTRIES OF SAN FRANCISCO

EARNINGS STATEMENT

RDP

RATE	HOURS	EARNINGS	TYPE	CLOCK NUMBER	NAME	DEPARTMENT		PERIOD ENDING
20000	7675	15350	REG	FULLT	WILLIAM CASTILLC	ARA		61277

DEDUCTIONS THIS PAY

FED. WITH. TAX	F.I.C.A.	S.U.I./DIS.	STATE WITH. TAX	CITY WITH. TAX
	856			

GROSS PAY	NET PAY	GROSS PAY	FED. WITH. TAX	F.I.C.A.	S.U.I./DIS.	STATE WITH. TAX	CITY WITH. TAX
15350	14452	324575	8403	18855			
EARNINGS THIS PAY		YEAR - TO - DATE TOTALS					

DETACH BEFORE CASHING

F-3-a-16

Eugene Chaiken

Pacific Telephone

THIS IS YOUR RECORD - PLEASE DETACH

NOV 3 1977 C807-0171

Code	Account Number	Public Tel Collections (less U.S. tax)	Deposit Amount	Interest	From Mo	From Day	To Mo	To Day	Amount
3	485 7600 727								14 06 B

The Attached Draft is in Payment of

CODE
1 Refund of Advance Payment
2 Refund of Deposit
3 Refund Of Overpayment on Final Bill
4 Commission on Public Telephone Collections
5 Credit Balance on Final Bill
6 Other (Detail Enclosed)

This is not a check - **DO NOT CASH**

F-3-a-17

Eugene Chaiken

Pacific Telephone

THIS IS YOUR RECORD - PLEASE DETACH

DEC 1 1977 C835-0311

Code	Account Number	Public Tel Collections (less U.S. tax)	Deposit Amount	Interest	From Mo	From Day	To Mo	To Day	Amount
3	485 7600 727								10 62 B

The Attached Draft is in Payment of

CODE
1 Refund of Advance Payment
2 Refund of Deposit
3 Refund Of Overpayment on Final Bill
4 Commission on Public Telephone Collections
5 Credit Balance on Final Bill
6 Other (Detail Enclosed)

This is not a check - **DO NOT CASH**

F-3-a-18

Savings Bank
OF MENDOCINO COUNTY

STATEMENT OF ACCOUNT

EUGENE B CHAIKEN TRUST ACCT 1
P O BOX 192
REDWOOD VALLEY CALIFORNIA 95470

ACCOUNT NUMBER	2-01372-2
STATEMENT DATE	01/31/78

BALANCE LAST STATEMENT	TOTAL AMOUNT CHECKS	NO. OF CHECKS	NO. OF DEPOSITS	TOTAL AMOUNT DEPOSITS	SERVICE CHARGE	BALANCE THIS STATEMENT
126233	00			00	00	126233

CHECKS	DEPOSITS	DATE	BALANCE

F-3-a-19

SC - SERVICE CHARGE
CC - CHECK CHARGE
MC - MISCELLANEOUS CHARGE
RT - RETURN CHECK

CUSTOMER COPY

Savings Bank OF MENDOCINO COUNTY

COMMERCIAL AND SAVINGS
SOUTH UKIAH OFFICE UKIAH, CALIFORNIA

No. 002999

80-406
1211

February 8, 19[illegible]

TO THE ORDER OF Eugene B. Chaikin $1,262.33

PAY SAVINGS BANK MENDOCINO CO. 1262 AND 33 CTS

REMITTED Our'l account 02-013722

COPY NOT NEGOTIABLE

BANK MONEY ORDER

VICE PRESIDENT CASHIER

F-3-a-20

PURCHASER'S RECEIPT - RETAIN FOR YOUR RECORDS

REMITTER

SAVINGS BANK OF MENDOCINO COUNTY
COMMERCIAL SAVINGS
UKIAH, CALIFORNIA

1108

Self - 01-07360-3

Dec. 9, 77

1-2
210

PAYABLE TO Eugene Chaikin

NOT NEGOTIABLE

12,455.88

SAVINGS BANK MENDOCINO CO. 12455 AND 88 CTS

THE CHASE MANHATTAN BANK
National Association
1 Chase Manhattan Plaza, New York, N. Y.

MEMORANDUM

FOR

F-3-a-21

THIS IS TO ADVISE YOU THAT WE HAVE THIS DAY
CHARGED YOUR ACCOUNT AS FOLLOWS:

DATE 12-9-77

ACCOUNT NUMBER 01 07360 3

DESCRIPTION	NUMBER	INTEREST	PRINCIPAL	BALANCE	AMOUNT	
Chase Manhattan draft - to close account # 1108					12,455	88
				TOTAL		

MAIL TO Eugene Chaikin

SAVINGS BANK OF MENDOCINO COUNTY

APPROVED BY

F-3-a-22

E. Chaikin

Blue Cross
of Northern California
1950 Franklin Street
Oakland, California 94659
Telephone: (415) 645-3000

12448074

EXPLANATION OF PAYMENTS

CHECK NUMBER 12448074

DATE OF ISSUE	CHECK AMOUNT
08/03/78	66.00

SERVICE PROVIDED BY	PATIENT	SERVICE FROM	TO	ID=566400602 EXPLANATION	CLAIM NUMBER	* TOTAL CHARGES	BLUE CROS BENEFITS
	SUB	05/10/7-	07/05/7	MAJOR MEDICAL	00263597	13800	660

these have gone over your signature for a deposit! no bill

THIS STATEMENT SHOWS THE AMOUNT PAID FOR HEALTH CARE SERVICES. YOU MAY WISH TO RECORD THIS PAYMENT. IF THE CHECK IS WRITTEN FOR TWO PAYEES, PLEASE ENDORSE IT AND SEND BOTH PARTS TO THE SECOND PAYEE.

F-3-a-23

* TOTAL CHARGES DO NOT INCLUDE PERSONAL ITEMS

Blue Cross
of Northern California
1950 Franklin Street
Oakland, California 94659
Telephone: (415) 645-3000

Chaikon

EXPLANATION OF PAYMENTS

CHECK NUMBER 9912160

DATE OF ISSUE 09/15/77

CHECK AMOUNT 21.50

0991216

SERVICE PROVIDED BY	PATIENT	SERVICE FROM	TO	ID=566400602 EXPLANATION	CLAIM NUMBER	* TOTAL CHARGES	BLUE CROSS BENEFITS
[redacted]	SUB	05/10/7	05/10/7	X-RAY AND LAB	00269828	2150	2150

THIS STATEMENT SHOWS THE AMOUNT PAID FOR HEALTH CARE SERVICES. YOU MAY WISH TO RECORD THIS PAYMENT. IF THE CHECK IS WRITTEN FOR TWO PAYEES, PLEASE ENDORSE IT AND SEND BOTH PARTS TO THE SECOND PAYEE.

F-3-a-24

* TOTAL CHARGES DO NOT INCLUDE PERSONAL ITEMS

[redacted]

[redacted]

P. Chaiken

Blue Cross
of Northern California
1950 Franklin Street
Oakland, California 94659
Telephone: (415) 645-3000

11671160

EXPLANATION OF PAYMENTS

CHECK NUMBER 11671160

DATE OF ISSUE 04/10/78

CHECK AMOUNT 4.95

SERVICE PROVIDED BY	PATIENT	SERVICE FROM	TO	ID=565508887 EXPLANATION	CLAIM NUMBER	* TOTAL CHARGES	BLUE CROSS BENEFITS
POST SCOTT P	DAU61	03/18/7	03/18/7	PRESCRIPTION	00979990	550	495

THIS STATEMENT SHOWS THE AMOUNT PAID FOR HEALTH CARE SERVICES. YOU MAY WISH TO RECORD THIS PAYMENT. IF THE CHECK IS WRITTEN FOR TWO PAYEES, PLEASE ENDORSE IT AND SEND BOTH PARTS TO THE SECOND PAYEE.

F-3-a-25

* TOTAL CHARGES DO NOT INCLUDE PERSONAL ITEMS

Blue Cross
of Northern California
1950 Franklin Street
Oakland, California 94659
Telephone: (415) 645-3000

12448052

P. Chaikin

EXPLANATION OF PAYMENTS

CHECK NUMBER 12448052

DATE OF ISSUE 08/03/78

CHECK AMOUNT 72.00

SERVICE PROVIDED BY	PATIENT	SERVICE FROM	TO	ID=565508887 EXPLANATION	CLAIM NUMBER	* TOTAL CHARGES	BLUE CROSS BENEFITS
	HUS	05/10/7-	07/05/7	HOME OR OFFICE	00263598		7200

THIS STATEMENT SHOWS THE AMOUNT PAID FOR HEALTH CARE SERVICES. YOU MAY WISH TO RECORD THIS PAYMENT. IF THE CHECK IS WRITTEN FOR TWO PAYEES, PLEASE ENDORSE IT AND SEND BOTH PARTS TO THE SECOND PAYEE.

F-3-a-26

* TOTAL CHARGES DO NOT INCLUDE PERSONAL ITEMS

Blue Cross
of Northern California
1950 Franklin Street
Oakland, California 94659
Telephone: (415) 645-3000

10174113

EXPLANATION OF PAYMENTS

Phyllis Charlene

CHECK NUMBER	DATE OF ISSUE	CHECK AMOUNT
10174113	11/03/77	14.00

SERVICE PROVIDED BY	PATIENT	SERVICE FROM	TO	ID=565508887 EXPLANATION	CLAIM NUMBER	* TOTAL CHARGES	BLUE CROSS BENEFITS
E LEVIN MD	SUB	08/04/7	08/04/7	SURGEON	00333144	2000	1400

THIS STATEMENT SHOWS THE AMOUNT PAID FOR HEALTH CARE SERVICES. YOU MAY WISH TO RECORD THIS PAYMENT. IF THE CHECK IS WRITTEN FOR TWO PAYEES, PLEASE ENDORSE IT AND SEND BOTH PARTS TO THE SECOND PAYEE.

F-3-a-27

* TOTAL CHARGES DO NOT INCLUDE PERSONAL ITEMS

Blue Cross
of Northern California
1950 Franklin Street
Oakland, California 94659
Telephone: (415) 645-3000

1022222

EXPLANATION OF PAYMENTS

CHECK NUMBER 10222223

DATE OF ISSUE 11/10/77

CHECK AMOUNT 9.00

SERVICE PROVIDED BY	PATIENT	SERVICE FROM	TO	ID=565508887 EXPLANATION	CLAIM NUMBER	* TOTAL CHARGES	BLUE CROSS BENEFITS
J KERNER MD	SUB	08/25/7	08/25/7	HOME OR OFFICE	00447012	5000	900

P. Charles

THIS STATEMENT SHOWS THE AMOUNT PAID FOR HEALTH CARE SERVICES. YOU MAY WISH TO RECORD THIS PAYMENT. IF THE CHECK IS WRITTEN FOR TWO PAYEES, PLEASE ENDORSE IT AND SEND BOTH PARTS TO THE SECOND PAYEE.

F-3-a-28

* TOTAL CHARGES DO NOT INCLUDE PERSONAL ITEMS

Blue Cross
of Northern California
1950 Franklin Street
Oakland, California 94659
1017150 Telephone: (415) 645-3000

P. Charlson

EXPLANATION OF PAYMENTS

CHECK NUMBER 10171508

DATE OF ISSUE	CHECK AMOUNT
11/03/77	38.40

SERVICE PROVIDED BY	PATIENT	SERVICE FROM TO	ID=565508887 EXPLANATION	CLAIM NUMBER	* TOTAL CHARGES	BLUE CROSS BENEFITS
	SUB	08/04/7-08/29/7	MAJOR MEDICAL	00333145	4800	3840

THIS STATEMENT SHOWS THE AMOUNT PAID FOR HEALTH CARE SERVICES. YOU MAY WISH TO RECORD THIS PAYMENT. IF THE CHECK IS WRITTEN FOR TWO PAYEES, PLEASE ENDORSE IT AND SEND BOTH PARTS TO THE SECOND PAYEE.

F-3-a-29

* TOTAL CHARGES DO NOT INCLUDE PERSONAL ITEMS

CO. #	EMPLOYEE #	TCD	PYRL.	HOME DEPT. #	NAME	PAYROLL PERIOD FROM	TO	DATE
2502	7386	7	50	6084	CHAIKIN, PHYLLIS	090577	090877	092277

24 ST. MARYS HOSPITAL 565-50-8887

48E

PAY #	JOB CODE	UNITS	AMOUNT
250	6084203002	8	420
		OBE TOTAL PAY	420

76E

DED. #	DESCRIPTION	AMOUNT
	F-3-a-30	
	TOTAL DEDUCTIONS	

FIT	FICA	DI	SIT	OTHER	NET	GROSS
100369	25 / 43496	04 / 7435	13910		391	766031

ST. MARY'S HOSPITAL AND MEDICAL CENTER

CO #	EMPLOYEE #	TCD	PAYROLL #	DEPT #	EMPLOYEE NAME	PAY PERIOD DATES FROM	TO	DATE
2502	7386	7	50	6084	PHYLLIS CHAIKIN	8-5-77	9-18-77	9 12 77

47A

PAY TYPE	I D	JOB CODE	W. C.	RATE	UNITS	PREMIUM TIME FACTOR	AMOUNT
11		6084103002	0001	5628	24 -		135 07
21		6084103002	0001	5628	8 -	1.50	67 53
41		6084203002	0001	5628	32 -		180 10
45		6084203002	0001	35	56 -		19 60
25		6084203002	0001	35	8 -	1.50	4 20
					08A TOTAL PAY		406 50

76A

DED. #	I D	DESCRIPTION	AMOUNT
		TOTAL VOLUNTARY DEDUCTIONS	—

7857 EMPLOYEE COPY F-3-a-31

WITHHELD TAXES					NET PAY
FIT	FICA	DI	SIT	OTHER TAX	
48 72	23 78	4 07	6 82	—	323 11

Bank of America Payroll Service

[redacted]

[redacted]

ST. MARY'S HOSPITAL AND MEDICAL CENTER
450 Stanyan Street • San Francisco, California 94117 • (415) 668-1000

NOTICE TO EMPLOYEE OF CHANGE OF RELATIONSHIP

(Issued pursuant to provisions of Section 1089
of the California Unemployment Insurance Code)

The employment of Phyllis Chaikin of Dept. 6084

has been terminated as of 9/13/77 Reason for

termination: Resigned

Date: 9/7/77

By M. Robblee
Personnel Department

F-3-a-32

F-3-a-33

CHECK NO.	CHECK DATE	PERIOD ENDING DATE	EMPLOYEE NO.	EMPLOYEE NAME
76709	09-16-77	09-11-77	15137	PHYLLIS CHAIKIN
RATE	REGULAR HOURS	OVERTIME HOURS	OTHER HOURS	
5.5300	8.00	.00	.00	

EARNINGS	REGULAR	OVERTIME	OTHER	MISCELLANEOUS	GROSS PAY
THIS PERIOD	44.24	.00	.00	.00	44.24
YEAR-TO-DATE	568.72	.00		.00	568.72

TAXES	FEDERAL W/H	STATE W/H	F.I.C.A.	S.D.I.	UNIFORM ALW
THIS PERIOD	.00	.24	2.59	.44	2.00
YEAR-TO-DATE	35.26	5.68	33.27	5.68	26.00

DEDUCTIONS	ADVANCE	UNION	MISC.	CD	MISC.	CD	MISC.	CD	NET PAY
THIS PERIOD	.00	.60	.00		.00		.00		42.37

PROFESSIONAL NURSES BUREAU, INC.
8430 SUNSET BLVD.
LOS ANGELES, CALIF. 90028

DEDUCTION CODES
P-PRIVATE DUTY FEES
G-GARNISHMENT
T-TAX GARNISHMENT

EMPLOYEE'S EARNINGS STATEMENT
THIS IS A RECORD OF YOUR EARNINGS AND DEDUCTIONS AS REPORTED TO THE FEDERAL AND STATE GOVERNMENTS.
PLEASE DETACH BEFORE CASHING.

Vernetta Christian

600089

THIS IS A STATEMENT OF YOUR EARNINGS AND DEDUCTIONS

DETACH AND RETAIN FOR YOUR RECORDS

PAY	SC	ST	B.U.	A.U.
	1	94	0015	212

FIREMAN'S FUND INSURANCE COMPANY

CHECK NO.

SOCIAL SECURITY NO.: TERM 07/22/77 VAC ADJ. FOR 8 DAYS

PERIOD | ENDING DATE | CHECK DATE: 08/27/77

OVERTIME/LOST TIME: FROM | TO

IMPOUND BALANCE

YEAR TO DATE TOTALS: TOTAL EARNINGS | FED. W/H | F.I.C.A. | OTHER | STATE | LOCAL

CURRENT EARNINGS

REGULAR	OVERTIME	SPECIAL	TOTAL EARNINGS	FED. W/H	F.I.C.A.	OTHER	STATE	LOCAL
		X 336 00	336 00	25 66	19 66	3 36	1 72	

D/S	CODE	AMOUNT	D/S	CODE	AMOUNT	CR. UNION ACCT. NO.	TOTAL DEDUCTIONS
	F-3-a-34						NET PAY 285 60

NON-NEGOTIABLE

VERN Christian

Pacific Telephone

This is Your Record - Please Detach

DEC 15 1977 S849-0114

Code	Account Number	Public Tel Collections (less U.S. tax)	Deposit Amount	Interest	From Mo	From Day	To Mo	To Day	Amount
2	567 9742 485		25 00	1 75	12	15	12	15	26 75

The Attached Draft is in Payment of

CODE 1 Refund of Advance Payment
2 Refund of Deposit
3 Refund Of Overpayment on Final Bill

CODE 4 Commission on Public Telephone Collections
5 Credit Balance on Final Bill
6 Other (Detail Enclosed

F-3-a-35

This is not a check - **DO NOT CASH**

THE ATTACHED CHECK IS IN FULL PAYMENT OF THIS SETTLEMENT AND ENDORSEMENT THEREON CONSTITUTES A RECEIPT OF SAME

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY
MAILING ADDRESS: P.O. BOX 2332, TERMINAL ANNEX
LOS ANGELES, CALIFORNIA 90051

DESCRIPTION	ACCOUNT	AMOUNT	DEDUCTIONS OR DISCOUNT	NET AMOUNT
MDO Policy Surrender, Policy No. S60001215		$336.07		
Additional Insurance		10.89		$346.96
1107-101				
Arvella Cole F-3-a-36				

VOUCHER No. 66098

DETACH BEFORE DEPOSITING • THIS STATEMENT IS FOR YOUR RECORD

Detach this stub and save for your payment records

The check attached to this information stub is a benefits payment provided by:

STANFORD UNIVERSITY HOSPITAL

44W 861840
check number

The following shows the date and composition of the attached check.

AUG 01 1977 GROSS AMT $48.92
FIXED DOLLAR ANNUITY $44.65
VAR ANNUITY-INV.FUND $4.27 = (UNITS) X (UNIT VALUE) 3.18 X 1.34345572
NET AMOUNT $****48.92

Please forward this stub to:

INEZ S CONEDY**********

F-3-a-37

Your identification number is:

009184 444163639

Detach this stub and save for your payment records

The check attached to this information stub is a benefits payment provided by:

STANFORD UNIVERSITY HOSPITAL

check number
44W 766117

The following shows the date and composition of the attached check.

AUG 15 1977

FIXED DOLLAR ANNUITY $48.76

Please forward this stub to:

INEZ S CONEDY***

F-3-a-38

Your identification number is:

9184 444-16-3639

NET AMOUNT $***48.76

Detach this stub and save for your payment records

The check attached to this information stub is a benefits payment provided by:

STANFORD UNIVERSITY HOSPITAL

44W 914138
check number

The following shows the date and composition of the attached check.

OCT 01 1977 GROSS AMT $48.74
FIXED DOLLAR ANNUITY $44.65
VAR ANNUITY-INV.FUND $4.09 = (UNITS) X (UNIT VALUE) 3.18 X 1.28714143
NET AMOUNT $****48.74

Please forward this stub to:

INEZ S CONEDY**********

F-3-a-39

Your identification number is:

009184 444163639

The check attached to this information stub is a benefits payment provided by:
STANFORD UNIVERSITY HOSPITAL

44W 967254
check number

Detach this stub and save for your payment records

The following shows the date and composition of the attached check.

DEC 01 1977 GROSS AMT	$48.54		(UNITS) X (UNIT VALUE)
FIXED DOLLAR ANNUITY	$44.65		
VAR ANNUITY-INV.FUND	$3.89	=	3.18 X 1.22172260
NET AMOUNT	$****48.54		

Please forward this stub to:
INEZ S CONEDY**********

F-3-a-40

Your identification number is:
009184 444163639

EMPLOYEE'S EARNINGS STATEMENT - DETACH AND RETAIN FOR TAX RECORDS

EMPLOYEE NAME	DEPT.	EMPLOYEE NUMBER	PERIOD ENDING	CHECK NUMBER
I CONEDY	21-3	444-16-3639-8	07/23/77	171104

EARNINGS			TAXES AND DEDUCTIONS		
TYPE OF EARNINGS	HOURS	AMOUNT	TYPE OF DEDUCTIONS	CURRENT AMOUNT	YEAR-TO-DATE AMT.
REGULAR	16.0	92.22	FEDERAL W/H	5.83	52.04
SHIFT DIFF.		9.22	FICA	5.93	51.96
			SDI	1.01	8.88
			STATE W/H		

NOT NEGOTIABLE

F-3-a-41

YR TO DATE GROSS EARN	CURRENT GROSS EARNINGS	LESS	TOTAL CURRENT DEDUCTIONS	NET CHECK AMT.
888.06	101.44		12.77	****88.67

STANFORD UNIVERSITY HOSPITAL
STANFORD, CALIFORNIA 94305

FORM 01-110 (5-75)

STANFORD UNIVERSITY HOSPITAL INEZ CONEDY 04972
STANFORD, CALIFORNIA 94305

REMITTANCE ADVICE

DESCRIPTION	DATE	VOUCHER	GROSS AMOUNT	DISCOUNT	NET AMOUNT
*AP MAY JUN	07 77	66909	21.60		21.60

F-3-a-42

TOTAL

RSPN 53 *SEE ATTACHMENT.

Presbyterian Hospital of Pacific Medical Center

P.O. BOX 37480 • SAN FRANCISCO, CALIFORNIA 94137
TRS # 94-1490928 (415) 563-4321

STATEMENT

SERVICE DATE FROM	STATEMENT DATE	PAGE
05/30/77 1835	08/13/77	1

1 ACTIVITY

PATIENT CORDELL, LORETTA
ACCOUNT NO. F26234

SERVICE TYPE: EMG
TO:
PHYSICIAN: ROKEACH

GUARANTOR

60

CORDELL, LORETTA
431 30TH AVE
SAN FRANCISCO CA 94121

INSURANCE
1 BLUE CROSS
2

312 36 4286
SOCIAL SECURITY NUMBER

AMOUNT OF THIS PAYMENT $

PLEASE INDICATE ANY CHANGE OF ADDRESS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT
SEE REVERSE SIDE FOR MAILING INSTRUCTIONS

BILLING DATE	SERVICE DATE	SERVICE CODE	DESCRIPTION	QTY.	CHARGES/PAYMENTS	BALANCE
			BALANCE FORWARD		0.00	0.00
06/02	05/30/77	29000010	EMERGENCY DEPT BASIC FEE	1	20.00	20.00
06/02	05/30/77	29004300	MISC ORTHO PROCEDURES	1	15.00	35.00
06/02	05/30/77	29190510	M.D. FEE RVS 90510	1	24.00	59.00
05/31	05/30/77	41404750	XRAY-EXAM EXT.BEYOND HRS	1	12.10	71.10
05/31	05/30/77	41473570	XRAY-KNEE, COMPL STUDY	1	43.00	114.10
07/08	07/08/77	01000051	PAYMENT-THANK YOU 053077	1	114.10-	0.00
07/19	07/19/77	01000060	BLUE CROSS PAYMT 053077	1	15.00-	15.00-
07/19	07/19/77	01000060	BLUE CROSS PAYMT 052577	1	90.10-	105.10-
07/19	07/19/77	01000060	BLUE CROSS PAYMT 052577	1	9.00-	114.10-

The responsibility for payment of this bill rests with the Guarantor.

F-3-a-43

PATIENT ACCT. NO.	PATIENT NAME		
F26234	CORDELL, LORETTA	TOTAL CHARGES	114.10
		TOTAL PAYMENTS	228.20-

0.00
0.00

Laboratory, Cardiology Laboratory, and Radiology charges include professional fees for services provided by:
R.J. KLEINHENZ, M.D. & ASSOCIATES - PATHOLOGISTS
ARTHUR SELZER, M.D. & ASSOCIATES - CARDIOLOGISTS
SAN FRANCISCO RADIOLOGISTS MEDICAL GROUP, INC.

PRESBYTERIAN HOSPITAL OF PACIFIC MEDICAL CENTER
P.O. BOX 37480
SAN FRANCISCO, CALIF. 94137

AMOUNT DUE 114.10- ORIGINAL

DATE	REFERENCE	GROSS AMOUNT	DISCOUNT	PREVIOUS BALANCE	BALANCE	REMARKS
JAN 1978		114.10			114.10	Refund F26234

F-3-a-44

Loretta Cordell

Presbyterian Hospital of Pacific Medical Center
CLAY AT BUCHANAN STREET, SAN FRANCISCO, CALIFORNIA 94115

NORMAN HARRIS
RONALD B. BERNSTEIN
GERALD E. RIGGS
STEVEN J. WEBER
NORMAN HARRIS, INC.
ROBERT BERKOWITZ

LAW OFFICES
HARRIS, BERNSTEIN, RIGGS, WEBER & BERKOWITZ
AN ASSOCIATION INCLUDING A PROFESSIONAL CORPORATION
703 FOX PLAZA
1390 MARKET STREET
SAN FRANCISCO, CALIFORNIA 94102

TELEPHONE
(415) 626-2865
(415) 864-6300

April 13, 1978

Jean F. Brown
Attorney at Law
Post Office Box 15156
San Francisco, CA 94115

RE: Ruby Carroll

Dear Ms. Brown:

Pursuant to your request, enclosed herewith is draft No. 131627 in the total amount of $1500.00 along with Release of All Claims. I am also enclosing an acknowledgment which requires your signature before a Notary Public.

After you have executed the above documents, it would be most appreciated if you would please return same to my office in the enclosed stamped-addressed envelope. As soon as the draft has been deposited in a trust account and cleared (10 working days), the settlement funds can be disbursed.

Should you have any questions, please do not hesitate to give me a call.

Very truly yours,

Gerald E. Riggs

/jp
Enclosures

F-3-a-45

POWER OF ATTORNEY

I, Ruby Carroll, hereby give power of attorney to Jean F. Brown to negotiate and to accept any settlement on my behalf with defendants, arising out of an automobile accident which occurred on October 17, 1976. I do specifically authorize her to sign my name to all releases, dismissals, drafts, checks, and any and all other documents whatsoever necessary to effectuate a settlement of my claim.

Dated: 3/8/78

Ruby Carroll
Ruby Carroll

Mary Lou Clancy 3/8/78
Ann Elizabeth Moore 3/8/78

E-3-a-46a

COPY

To Whom It May Concern:

It is not possible to have the power of attorney I have given to Jean F. Brown, notarized, as the nearest notary, or commissioner of Oaths is 300 miles away.

Ruby J Carroll

Ruby J. Carroll

3/10/78

Date

Mary Lou Clancy 3/10/78

Ann Elizabeth Moore 3/10/78

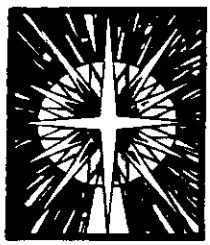
F-3-a-46b

SETTLEMENT STATEMENT

Ruby Carroll

GROSS SETTLEMENT RECEIVED	$ 1500.00	
LESS COSTS ADVANCED.	$ 37.44	
NET SETTLEMENT.	$ 1462.56	
LESS ATTORNEY'S FEES (33 1/3%)	$ 487.52	
GROSS PAYABLE TO CLIENT		$ 975.04
LESS DEDUCTIONS:		
MEDICAL		
TOTAL DEDUCTIONS.	$ -0-	
NET PAYABLE TO CLIENT		$ 975.04

F-3-a-47



PEOPLES
TEMPLE
OF THE
DISCIPLES OF CHRIST
P.O. Box 15023
San Francisco
California 94115

Ruby Carrolls settlement

Check Signed & Sent in

Check needs to Be Signed
by Ruby

Her settlement Check

F-3-a-48

M. Darnes

Pacific Telephone

This Is Your Record - Please Detach

SEP 19 1977

S762-0070

Code	Account Number	Public Tel Collections (less U.S. tax)	Deposit Amount	Interest	From Mo	From Day	To Mo	To Day	Amount
3	626 5821 235								5 85

The Attached Draft is in Payment of

CODE
1 Refund of Advance Payment
2 Refund of Deposit
3 Refund Of Overpayment on Final Bill
4 Commission on Public Telephone Collections
5 Credit Balance on Final Bill
6 Other (Detail Enclosed)

F-3-a-49

This is not a check - **DO NOT CASH**

CITY/COUNTY OF SAN FRANCISCO 0697 5240304570 08-30-77 24108

DELANEY, EDITH

29652

29652	00	00	=	29652
88503	00	00	=	88503

REGULAR 29652 88503

NOT NEGOTIABLE

F-3-a-50

STATEMENT OF EARNINGS AND DEDUCTIONS • DETACH AND RETAIN FOR YOUR RECORDS

CITY/COUNTY OF SAN FRANCISCO 0697 5240304570 09-30-77 35239

DELANEY, EDITH

29652

29652	00	00	=	29652
118155	00	00	=	118155

REGULAR 29652 118155

NOT NEGOTIABLE

F-3-a-51

STATEMENT OF EARNINGS AND DEDUCTIONS • DETACH AND RETAIN FOR YOUR RECORDS

CITY/COUNTY OF SAN FRANCISCO 0697 5240304570 11-30-77 59856

DELANEY, EDITH 29652

29652	00	00	= 29652
352653	00	00	= 352653

REGULAR 29652 352653

NOT NEGOTIABLE

F-3-a-52

STATEMENT OF EARNINGS AND DEDUCTIONS • DETACH AND RETAIN FOR YOUR RECORDS

R. Dominick

Pacific Telephone

This Is Your Record - Please Detach

S743-0036

AUG 31 1977

Code	Account Number	Public Tel Collections (less U.S. tax)	Deposit Amount	Interest	From Mo.	From Day	To Mo.	To Day	Amount
5	563 6080 120								2 69

The Attached Draft is in Payment of

CODE
1 Refund of Advance Payment
2 Refund of Deposit
3 Refund Of Overpayment on Final Bill
4 Commission on Public Telephone Collections
5 Credit Balance on Final Bill
6 Other (Detail Enclosed)

F-3-a-53

This is not a check - DO NOT CASH

CONNETT AGENCIES
General Insurance

520 Van Ness Ave.
San Francisco, Calif. 94102
431-6986

James EDWARDS
2708 21st St
San Francisco 94110

8/4/77

Re: Reserve Auto policy C04 670946

Please find enclosed our check # 15311 in the amount of $ 173 00

which represents Refund due for deleting 69 Chev Station wag

Sincerely yours,
CONNETT AGENCIES

F-3-a-54

PURCHASER'S RECEIPT - RETAIN FOR YOUR RECORDS

C 235831

11-2627/05

Bank of Montreal
(California)
SAN FRANCISCO, CALIFORNIA

August 31 77 11-3 1210

PAYABLE TO NOT NEGOTIABLE

James & Irene Edwards *118.00*

BANK OF MONTREAL (CALIFORNIA) 118 AND 00 CTS

CASHIER'S CHECK

Bank per request
Sept. payment on IC 1013
less $1.00 Collection fee

119.00

F-3-a-55

⑆1210⑈00031⑆ 01 200 500⑈ 30

PURCHASER'S RECEIPT - RETAIN FOR YOUR RECORDS

C 35832

11-2627/05

Bank of Montreal
(California)
300 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

August 31 77 11-3 1210

PAYABLE TO *** James & Irene Edwards *** NOT NEGOTIABLE *118.00*

BANK OF MONTREAL (CALIFORNIA) ONE HUNDRED EIGHTEEN AND 00 CTS

CASHIER'S CHECK

Oct. payment on IC 1013
less $1.00 Collection fee.

118.00

F-3-a-56

⑆1210-0003⑆ 01 200 500⑈ 30

PURCHASER'S RECEIPT - RETAIN FOR YOUR RECORDS

C 36555

11-2627/05

Bank of Montreal
(California)
300 CALIFORNIA STREET
SAN FRANCISCO, CALIF. 94104

December 20 77 11-3 1210

PAYABLE TO *** James and Irene Edwards *** NOT NEGOTIABLE *238.00*

BANK OF MONTREAL (CALIFORNIA) TWO HUNDRED THIRTY-EIGHT AND 00 CTS

CASHIER'S CHECK

Proceeds on IC. #1013

238.00

F-3-a-57

⑆1210-0003⑆ 01 200 500⑈ 30

[redacted]

EMPLOYEE'S STATEMENT OF EARNINGS AND DEDUCTIONS - DETACH AND RETAIN

SAKS AGENCY, INC.

PERIOD ENDING Sept. 12, 1977

NAME Fred Eichler

REGULAR HOURS @	3	17	50	72
OVERTIME HOURS @				
TOTAL EARNINGS			50	72
SOCIAL SECURITY TAX	2	97		
WITHHOLDING U. S. INCOME TAX		00		
S. D. I.		51		
STATE INCOME TAX		00		
F-3-a-58				
TOTAL DEDUCTIONS			3	48
NET PAY			47	24

[redacted]

BANK OF AMERICA

NORTHRIDGE OFFICE

March 28, 1978

Mr. and Mrs. Donald Fields
P. O. Box 15156
San Francisco, CA 94115

Dear Mr. and Mrs. Fields:

Checking accounts are normally used as a convenient means of paying bills and providing a record of payments. I notice that your account has not been used for several months, and I wonder if it is filling your needs. If not, our bank has several kinds of savings accounts that might better serve your needs and also pay you interest on your inactive funds.

We are inquiring because checking accounts inactive for six months are transferred to a special "dormant" category. These accounts are then charged a service charge of $1.00 per month. If you want your account to remain as it is, it won't be changed, but please let me know within 30 days if this is the case.

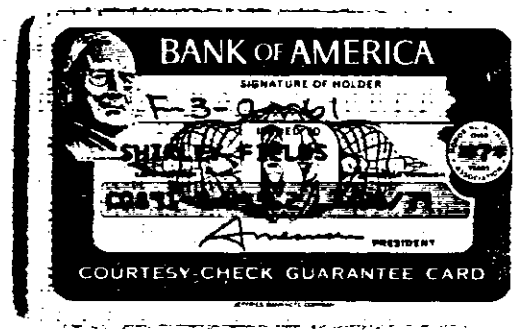
My telephone number is 349-2170.

Sincerely,

Patricia Dix
Assistant Manager - Operations

F-3-a-59

BANK OF AMERICA
SIGNATURE OF HOLDER
PRESIDENT
COURTESY-CHECK GUARANTEE CARD


BANK OF AMERICA
SIGNATURE OF HOLDER
PRESIDENT
COURTESY-CHECK GUARANTEE CARD

BANK OF AMERICA

The Timesaver Statement

If you have any questions about this statement, please call us or bring this copy to your Bank of America branch.

NORTHRIDGE OFFICE
NORTHRIDGE CALIF

PERIOD ENDING
FEB 06, 1978
BRANCH PHONE NO.
213-349-2170

13 DONALD J. FIELDS
SHIRLEY FIELDS
P. O. BOX 15156
SAN FRANCISO CA 94115

0891-PS13

AT BANK OF AMERICA WE HAVE SIX DIFFERENT CHECKING PLANS TO CHOOSE FROM. THE CHOICE IS YOURS.

SUMMARY OF BANKING SERVICES (BALANCES SHOWN ARE AS OF STATEMENT DATE)

TYPE OF SERVICE	ACCOUNT NO	CHECKS NO	CHECKS AMOUNT	DEBITS NO	DEBITS AMOUNT	DEPOSITS NO	DEPOSITS AMOUNT	NEW BALANCE
CHECKING	0891-9-04562	1	200			0	00	4000
BANKAMERICARD/INSTANT CASH CREDIT AVAILABLE								155000

CHECKING ACCOUNT ACTIVITY (USE REVERSE SIDE FOR RECONCILING TO YOUR RECORDS)

CHECKS AND OTHER DEBITS						DEPOSITS	
CHECK NO	DATE PAID	AMOUNT	CHECK NO.	DATE PAID	AMOUNT	DATE	AMOUNT
SERV.CHGE.	2 6	200					

F-3-a-62

PREVIOUS BALANCE	AMOUNT OF ENTRIES YOU AUTHORIZED DEBITS	CREDITS	MINIMUM AVERAGE BALANCE	ENCLOSURES
$42.00	$2.00		$42.00MN	0

Key to Symbols: * Gap in Check Sequence
** Includes Interest Payment Last Period
A Automatic Deposit
MN or AV Minimum or Average Balance used for Service Charge Calculation
B BankAmericard Instant Cash
R Reversing Entry
M Miscellaneous
OD Overdrawn

BB-1 10-76 (REV.)

109017

PERIOD ENDED	DEPT. NO.	EMPLOYEE NAME	SOCIAL SECURITY
073077	346	DONALD J FIELDS 051244784	051244784

EMPLOYEE EARNINGS & DEDUCTIONS

NOT NEGOTIABLE

CHECK NUMBER

EARNINGS

TYPE	RATE	UNITS	AMOUNT
DAY SHIFT	05193200		30461

VOLUNTARY DEDUCTIONS

TYPE	AMOUNT

F-3-a-63

CURRENT GROSS 30461

DEDUCTION TOTALS

VOLUNTARY

STATUTORY 3108

NET PAY 27353

EMPLOYER: ST. LUKE'S HOSPITAL

CHECK NO	EXEMPTIONS FED	EXEMPTIONS STATE	YTD GROSS EARNINGS
16D346	04	04	740731

STATUTORY DEDUCTIONS

	FICA	STATE	S.D.I.	F.I.T.
CURRENT	1782		305	1021
YTD	43334	19147	7410	102702

RETAIN THIS STUB AS A RECORD OF YOUR EARNINGS & DEDUCTIONS

BANK OF AMERICA
NATIONAL TRUST AND SAVINGS ASSOCIATION

ADVICE OF CHARGE

No. 533024

NORTHRIDGE OFFICE # 891
BRANCH

MAY 23, 1978
DATE

WE HAVE CHARGED YOUR **CHECKING** ACCOUNT

BR. NO.	ACCT. NO.	TR. CODE	AMOUNT
891	9-4562		$ 35.00

TO CLOSE CHECKING ACCT. (9-4562) PER YOUR REQUEST BY LETTER & ISSUE CASHIER CHECK AS FOLLOWS.

(MAIL TO)
DONALD J. FIELDS
SHIRLEY FIELDS
% D. ADAMS
P.O. BOX 893
GEORGETOWN, GUYANA SO. AMERICA

MADE BY G. SNITKOFF

APPROVED BY
AUTHORIZED SIGNATURE

F-3-a-64 a

VERIFICATION STUB

No. 0891 49589

DATE 891 MAY 23 78

AMOUNT $ 35.00

CASHIER'S CHECK
DRAWN ON
Northridge Branch
Bank of America
NATIONAL TRUST & SAVINGS ASSOCIATION

F-3-a-64 b

SIGNED BY

FX-266 6-77 (REV.)

Don + Shirlee Fields

January 16, 1978

To Our Shareholders:

We are pleased to enclose a check representing a special cash dividend of $0.05 per share on McFarland Energy, Inc. common stock, payable on January 17, 1978 to shareholders of record December 20, 1977. This is our first cash dividend since the merger with Seaboard Oil & Gas Co. in February 1976. While the Board of Directors, at this time, has not committed itself to cash dividends on a regular basis, it is hoped that our future earnings and capital requirements will permit subsequent cash payments to shareholders. Please cash the enclosed check promptly. We take this opportunity to wish you a happy and prosperous 1978.

F-3-a-65

Sincerely,

McFARLAND ENERGY, INC.

PEOPLES NATIONAL BANK & TRUST COMPANY
BAY CITY, MICHIGAN

PNB

37786

July 31, 1978

006-1553-4
Selma Weinberg

Shirley Ann Fields

F-3-a-66

$1,000.00

Specific Bequest

P

Replaces check #34694, dated 3-28-78
Payment stopped 7-31-78.

PLEASE DETACH AND RETAIN THIS STUB

BANK OF AMERICA

The Timesaver Statement

If you have any questions about this statement, please call us or bring this copy to your Bank of America branch.

NORTHRIDGE OFFICE
NORTHRIDGE CALIF

PERIOD ENDING
JUL 08, 1977
BRANCH PHONE NO.
213-349-2170

F-3-a-67 PS13

13 DONALD J. FIELDS
SHIRLEY FIELDS
P. O. BOX 15156
SAN FRANCISO CA 94115

IF YOU WANT TO DOUBLE YOUR MONEY, ASK ABOUT OUR NEW 10 YEAR GROWTH CERTIFICATES—THEY ARE A SURE THING

SUMMARY OF BANKING SERVICES (BALANCES SHOWN ARE AS OF STATEMENT DATE)

TYPE OF SERVICE	ACCOUNT NO.	CHECKS · DEBITS NO.	CHECKS · DEBITS AMOUNT	DEPOSITS NO.	DEPOSITS AMOUNT	NEW BALANCE
CHECKING	0891-9-04562	6	31941	0	00	116474
BANKAMERICARD/INSTANT CASH CREDIT AVAILABLE						100000

CHECKING ACCOUNT ACTIVITY (USE REVERSE SIDE FOR RECONCILING TO YOUR RECORDS)

CHECKS AND OTHER DEBITS						DEPOSITS	
CHECK NO	DATE PAID	AMOUNT	CHECK NO.	DATE PAID	AMOUNT	DATE	AMOUNT
539	616	800					
540	613	3368					
541	610	5000					
542	614	4473					
543	623	10800					
544	630	7500					

PREVIOUS BALANCE	AMOUNT OF ENTRIES YOU AUTHORIZED DEBITS	CREDITS	MINIMUM AVERAGE BALANCE	ENCLOSURES
$1,474.15			$1258.00AV	6

Key to Symbols: * Gap in Check Sequence
** Includes Interest Payment Last Period
A Automatic Deposit
MN or AV Minimum or Average Balance used for Service Charge Calculation.
B BankAmericard® Instant Cash
R Reversing Entry
M Miscellaneous
OD Overdrawn

BR-1 10-70 (REV.)

DONALD J. FIELDS
SHIRLEE ANN FIELDS
[redacted] PO BOX 15156
SAN FRANCISCO, CA. 94115

F-3-a-68 539

_____ 19__

Pay to the order of CALIFORNIA Society Hosp. PHARM $ 8.00

Eight + 00/100 Dollars

BANK OF AMERICA
NORTHRIDGE BRANCH
8180 RESEDA BLVD., NORTHRIDGE, CA 91324

Memo _____ Donald J Fields

⑆1220⑉0066⑆539⑉08919⑉04562⑈ ⑈0000000800⑈

DONALD J. FIELDS
SHIRLEE ANN FIELDS
998 DIVISADERO ST.
SAN FRANCISCO, CA. 94115

F-3-a-69 540

6/4 1977

Pay to the order of Avenue Typewriter $ 33.68

Thirty three + 65/100 Dollars

BANK OF AMERICA
NORTHRIDGE BRANCH
8180 RESEDA BLVD., NORTHRIDGE, CA 91324

Memo _____ Donald J Fields

⑆1220⑉0066⑆540⑉08919⑉04562⑈ ⑈0000003368⑈

DONALD J. FIELDS
SHIRLEE ANN FIELDS
[redacted] PO BOX 15156
SAN FRANCISCO, CA. 94115

F-3-a-70 541

6-7 1977

Pay to the order of MONTEAGLE PHARMACY $ 50.00

Fifty + 00/100 Dollars

BANK OF AMERICA
NORTHRIDGE BRANCH
8180 RESEDA BLVD., NORTHRIDGE, CA 91324

Memo _____ Donald J Fields

⑆1220⑉0066⑆541⑉08919⑉04562⑈ ⑈0000005000⑈

DONALD J. FIELDS
SHIRLEE ANN FIELDS
998 DIVISADERO ST.
SAN FRANCISCO, CA. 94115

F-3-a-71 542

6/11 1977

Pay to the order of EARTHLY GOODS $ 44.73

Forty-Four + 73/100 Dollars

BANK OF AMERICA
NORTHRIDGE BRANCH
8180 RESEDA BLVD., NORTHRIDGE, CA 91324

Memo _____ Donald J Fields

⑆1220⑉0066⑆542⑉08919⑉04562⑈ ⑈0000004473⑈

945 Pay to the order of 945
BANK of AMERICA
NATIONAL TRUST AND SAVINGS ASSOCIATION
FOR DEPOSIT ONLY
CALIF SOCIETY OF
HOSP PHARMACISTS
09456 - 05612

JE '77 16
PAY ANY BANK, P.E.G.
BANK of AMERICA, NT & SA
LOS ANGELES, CA.

SAN FRANCISCO CENTER
WELLS FARGO BANK, N.A.
SAN FRANCISCO, CA.

11-143
JUN 8 1977
WELLS FARGO BANK
SAN FRANCISCO, CALIF.
PAY ANY BANK, P.E.G.
25th & MISSION OFFICE
11-142

FOR DEPOSIT ONLY
PAY TO THE ORDER OF
WELLS FARGO BANK, N.A.
11-2739 SAN FRANCISCO, CALIF. 11-2739
EARTHLY GOODS
0076 - 021526
P. E. G. PAY ANY BANK
WELLS FARGO BANK, N.A.
COW HOLLOW OFFICE #07
SAN FRANCISCO, CA

JE '77 13
PAY ANY BANK

DONALD J. FIELDS
SHIRLEE ANN FIELDS
998 DIVISADERO ST.
SAN FRANCISCO, CA. 94115

CS

F-3-a-72 543

6/14 1977

Pay to the order of SF SU Counseling Educ. $ 108.00

One hundred eight 00/100 Dollars

BANK OF AMERICA
NORTHRIDGE BRANCH
9160 RESEDA BLVD., NORTHRIDGE, CA 91324

Memo SS# 052-62-9901.

Donald J Fields

⑆1220⑈0066⑆543⑈08919⑈04562⑈ ⑈0000010800⑈

DONALD J. FIELDS
SHIRLEE ANN FIELDS
998 DIVISADERO ST.
SAN FRANCISCO, CA. 94115

F-3-a-73 544

6/27 1977

Pay to the order of Montenegro Rx $ 75.00

Seventy-five 00/100 Dollars

BANK OF AMERICA
NORTHRIDGE BRANCH
9160 RESEDA BLVD., NORTHRIDGE, CA 91324

Memo

Donald J Fields

⑆1220⑈0066⑆544⑈08919⑈04562⑈ ⑈0000007500⑈

MEMORANDUM
DETACH AND RETAIN

_____ 19____

$ _____

RECORD THIS WITHDRAWAL
IN YOUR CHECK BOOK

P 122 8 74 (REV.)

COUNTER RECEIPT NOT NEGOTIABLE _____ 19____

RECEIVED OF BANK OF AMERICA
NATIONAL TRUST AND SAVINGS ASSOCIATION $ _____

_____ DOLLARS

THIS RECEIPT IS FOR USE ONLY AT THE COUNTER OF THE BANK BY THE DEPOSITOR PERSONALLY AND IS NOT NEGOTIABLE

FROM MY CHECKING ACCOUNT NO. _____

_____
STREET ADDRESS

_____ _____
CITY SIGNATURE

⑆5100⑈1229⑆

F-3-a-74

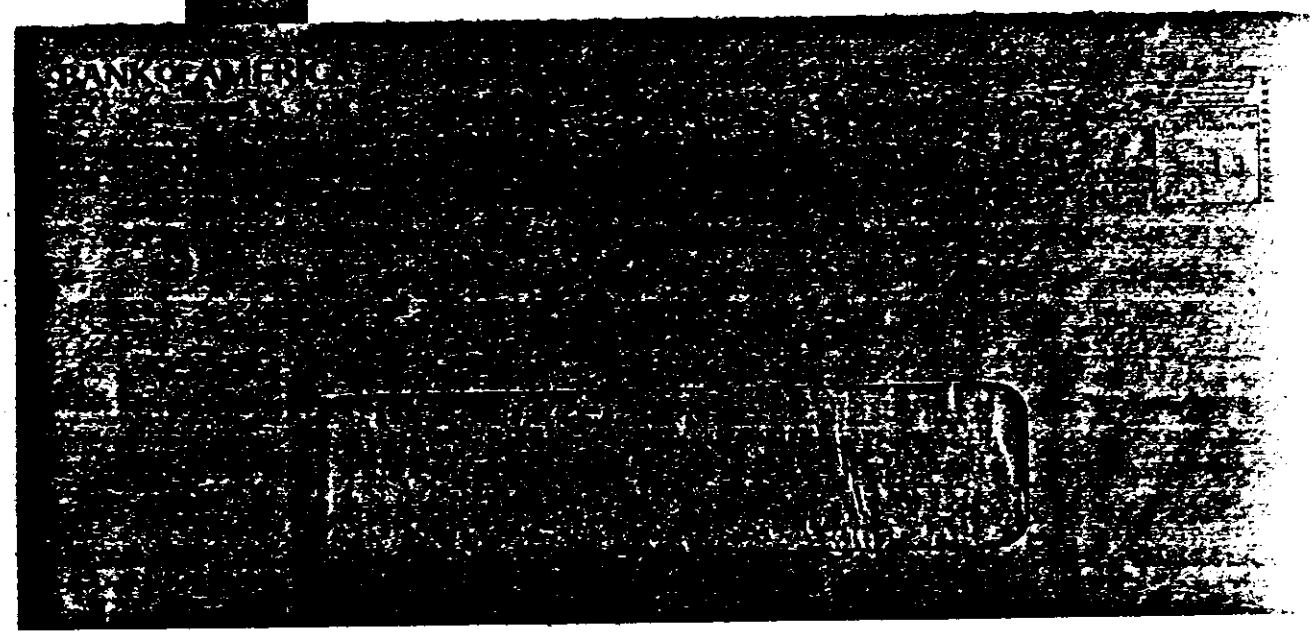
JE '77 22

WELLS FARGO BANK
SAN FRANCISCO, CALIF.
049
PAY TO THE ORDER OF
THE WELLS FARGO BANK
FOR IMMEDIATE
ACTIVE TRUST
11-203
JUN 17 1977
049 PAY ANY BANK, P. E. C.
STONESTOWN OFFICE
SAN FRANCISCO STATE UNIVERSITY
SAN FRANCISCO, CALIFORNIA

JE '77 29

PROCESSED
WELLS FARGO BANK
SAN FRANCISCO, CA.
PAY ANY BANK

WELLS FARGO BANK
061 SAN FRANCISCO
11-142
JUN 29 1977
061 PAY ANY BANK, P. E. C.
29th & MISSION OFFICE
061



[redacted] [redacted]

CHECKING
08969 - 04562
CD 13--76

DONALD J. FIELDS
P. O. BOX 15156
SAN FRANCISO CA 94115

NORTHRIDGE OFFICE

DONALD J. FIELDS 13—76
COUED

CHECKING 08969 - 04562

08969-04562

F-3-a-76

CHECKING
08969 - 04562
CD 13--76

SHIRLEY FIELDS
P. O. BOX 15156
SAN FRANCISO CA 94115

NORTHRIDGE OFFICE

SHIRLEY FIELDS 13—76
COUED

CHECKING 08969 - 04562

08969-04562

ACCOUNT DETAIL

POLICY NO. E4-84-28-1 CHECK NO. 545316 ACCOUNT BALANCE

DATE	EXPLANATION	AMOUNT	DATE	EXPLANATION	AMOUNT	DATE	EXPLANATION	AMOUNT
	S.C.	5.40	5-06	PREM	300.00	5-06	PMT	90.30-
6-09	PMT	23.30-	6-15	PREM	187.00	7-07	PMT	47.54-
8-05	PMT	47.58-	9-13	PMT	47.58-	10-10	PMT	47.58-
12-21	PREM	198.00-	12-21	DISB	9.48			

Maureen Fitch

F-3-a-77

SD=SAVINGS DIVIDEND BAL=LAST YEAR'S BALANCE SC=SERVICE CHARGE CK RT=CHECK RETURNED BY BANK DISB=OUR CHECK TO YOU

F-3-a-78

California State Automobile Association • Inter-Insurance Bureau
150 Van Ness Avenue, San Francisco, California 94101 • (415) 565-2394

AUTOMOBILE

FITCH MAUREEN CYNTHIA
% MISSION VILLAGE P O
BOX 853
GEORGETOWN GUYANA SAAA
00000

DECEMBER 22, 1977

CONFIRMATION OF CANCELLATION

This policy was cancelled on the date stated below for non-payment of premium in accordance with the cancellation notice previously mailed to you. There is not now nor has there been, any insurance in effect under this policy since that date.

Enclosed is a statement if a balance is due us, or a check if an amount is due you.

Please contact your local District Office if you have any questions regarding your cancelled policy, or the availability of future insurance protection.

POLICY NUMBER	CANCELLATION DATE	AMOUNT OF STATEMENT	AMOUNT OF CHECK
E48428-1	12-09-77	$	$ 9.48

COLLECTION CORRESPONDENCE

cc

SAN FRANCISCO
038

INSURED

F-3-a-79

No. 20,109,522

EMPLOYEE'S STATEMENT OF EARNINGS, DEDUCTIONS AND LEAVE

IDENTIFICATION				EARNINGS MAR 17 1978			
NAME	CONTROL	SOCIAL SECURITY NO.	PERIOD ENDING	REGULAR PAY	OVERTIME PAY	OTHER PAY	NET PAY
THOMAS R FITCH	267257	570-66-0550	03116	53680			40123

DEDUCTIONS

HEALTH INS	LIFE INS	UNION DUES	ALIMONY	BONDS	CSRA/FICA	STATE WH TAX	FEDERAL WH TAX	CHAR CONTR	TAX	OTHER	CHECK NUMBER
1307			2000		3758	808	5684				[illegible]

LEAVE

ANNUAL LEAVE RATE	ANNUAL LEAVE TAKEN	ANNUAL LEAVE AVAIL	ANNUAL LEAVE WAIVED	SICK LEAVE TAKEN	SICK LEAVE AVAIL	COMP. TIME TAKEN	COMP. TIME AVAIL	LVPD	CLOCK
60	41	[illegible]		[illegible]	[illegible]			031178	

DISCLOSURE OF OTHER DEDUCTIONS NOT CAPTIONED

2 U.S.A. DISBURSING OFFICER

NON NEGOTIABLE
DO NOT CASH

INFORMATION ONLY

RETAIN THIS STATEMENT AS A PERMANENT RECORD OF YOUR EARNINGS, DEDUCTIONS AND LEAVE

NAVCOMPT Form 906-2 (Rev. 8-70)

PG and E PLEASE DETACH Maureen Fitch REFUND NO. 218907

ACCOUNT NUMBER
TRG2954526

JANUARY 17 1978

OVERPAYMENT ON CLOSED ACCOUNT $*********20.08

998 DIVISADERO ST #301
SN FRANCISCO CA 94115

F-3-a-80

61-7117
10-74

COURT TRUSTEE

COUNTY OF LOS ANGELES

Betty Fountain

WARRANT NO.	CASE NO.	ISSUE DATE	TOTAL AMT.
1411607	D849085	090178	007500

CHILD SUPPORT	ARREARS	ALIMONY	OTHER
7500			

F-3-a-81

NOT NEGOTIABLE 0603

KEEP THIS PORTION FOR YOUR RECORDS

Ernest Griffin

PLEASE DETACH THIS REMITTANCE ADVICE BEFORE DEPOSITING CHECK

YOUNG MEN'S CHRISTIAN ASSOCIATION OF SAN FRANCISCO
220 GOLDEN GATE AVENUE
SAN FRANCISCO, CALIFORNIA 94102

THE ATTACHED CHECK IS IN PAYMENT OF THE ITEMS LISTED BELOW

	8 31 77	60.00	0.00	60.00	RETIREMENT AUG 77 2202 8A 6000 F-3-a-82

PLEASE DETACH THIS REMITTANCE ADVICE BEFORE DEPOSITING CHECK

YOUNG MEN'S CHRISTIAN ASSOCIATION OF SAN FRANCISCO
220 GOLDEN GATE AVENUE
SAN FRANCISCO, CALIFORNIA 94102

THE ATTACHED CHECK IS IN PAYMENT OF THE ITEMS LISTED BELOW

	9 30 77	60.00	0.00	60.00	RETIREMENT FOR SEP 77 F-3-a-83

SEP 14 1977

Type or print name, address and Social Security number the same as above.

SOCIAL SECURITY NUMBER
538-38-8992

Mail check to:

Lemuel T. Grubbs

FIRST NAME | INITIAL | LAST NAME

~~GRUBBS, LEMUEL~~

STREET ADDRESS
c/o2451 Road "K"

CITY | STATE | ZIP CODE
Redwood Valley, CA 95470

Here is your check covering the refund of your contributions. Your membership in the Teachers' Retirement System has been terminated.

F-3-a-84

STATE TEACHERS' RETIREMENT SYSTEM
State Teachers' Retirement System
1416 - 9th Street
Sacramento, California 95814

FORM R10 (REV. 8-71)

F-3-a-85

university benefits of california

Summary of Insurance Benefits

		Campus	Date
GRUBBS	S E	SAN FRANCISCO	09/01/77
2231 SUTTER ST		Employee No.	Birthdate
SAN FRANCISCO CA 94115		321500	11/10/38
		Social Security No.	
		548-50-7590	

The information provided below reflects University records concerning your group insurance as of September coverage. The purpose is to keep you informed of the status of your insurance coverage, thereby enabling you to better analyze your financial picture and to plan for financial needs in the event of death and disability. In planning, you should also take into account the potential effect of your benefits from your retirement system.

In analyzing this summary, please keep in mind that any insurance action initiated after September 1 will not be reflected on this statement. The premium cost and amount of coverage for Employee-paid Life Insurance and Short Term Disability is based on salary and age as of January 1, 1977, and remains constant until the following January 1. Any adjustment in amount or premium since January 1 will be reflected on next year's insurance summary.

The summary is sent at this time to allow you to review your insurance coverage prior to the annual open enrollment period in November. Please see reverse side for more complete details on *OPEN ENROLLMENT*.

Group Health Plan Coverage

Protection for you and your family is available under several plans. You are presently enrolled as follows:

Name of Plan	Coverage	Premium Per Month	Employer Contribution
BLUE CROSS	EMPLOYEE	52.50	32.00

Employee-Paid Life Insurance (Equitable Life Assurance Society) Premium and amount are based upon salary as of January 1, 1977.

There are four life insurance plans: One, Two and Three Times annual salary rate and a flat $2000. All plans but the flat $2000 offer protection against loss of income due to total and permanent disability occurring before age 60.

Coverage	Amount	Free Insurance*	Total Amount	Your Cost Per Month
NOT ENROLLED				

*15% additional free insurance

The amount of insurance will be reduced 10% on the January 1 coinciding with or next following attainment of age 60 and 10% thereafter.

Dependent Life Insurance (Equitable Life Assurance Society)

You may enroll your eligible dependents (spouse and children from birth to 21 years as well as unmarried children who are full time students up to age 23) if you are enrolled in the employee Group Life Plan. The benefit is $1,500 ($1,000 if you are enrolled in the flat $2,000 plan) except for children from the age of birth to 6 months, for whom the benefit is $100.

Coverage	Your Cost Per Month
NOT ENROLLED	

Employee-Paid Short Term Disability Supplement Insurance (Equitable Life Assurance Society) Premium is based on salary and age as of January 1, 1977.

If you become ill or hurt and cannot work, you will receive 70% of your average earnings up to a maximum benefit of $1500 per month, when coordinated with Nonindustrial Disability Plan A after use of sick leave (up to a maximum of 90 days) or following the waiting period selected, whichever is later. Benefits are payable for up to 52 weeks for each period of disability.

Waiting Period	Your Cost Per Month
15 DAYS	2.20

You may increase the waiting period anytime you wish. You may also decrease the waiting period by submitting a statement of health to the Equitable for approval. If you <u>are</u> <u>not</u> enrolled, you may apply by submitting a statement of health to the carrier. University Employees are covered by Nonindustrial Disability Insurance. (See reverse side of page for complete explanation.)

Accidental Death and Dismemberment (American Home Assurance Company)

City	State	Zip
Redwood Valley,	CA	95470

Sacramento,

Form R10 (REV. 8-71)

university benefits of california

OPEN ENROLLMENT

Group Life Insurance and Health plans will be "open" for enrollment from Tuesday, November 1 to Wednesday, November 30, 1977. You are eligible to enroll in any plan (except the Short Term Disability Supplement) if you are appointed to work full time for three months or more or 50% time for one year or more. During this time you may enroll, change life insurance or health plans or add previously uninsured family members. New enrollment will be effective on January 1, 1978.

If you have any questions, wish to add or change coverge or request brochures describing the coverage, you may contact the Departmental Secretary at the Davis, San Francisco, Berkeley, Los Angeles and Irvine campuses. At the Santa Cruz, San Diego, Santa Barbara and Riverside campuses contact the campus Benefits Representative in the Personnel Office.

EMPLOYER PAID LIFE INSURANCE

Life Insurance in the amount of $5000 is provided free for all employees who are regular members of a basic retirement system to which the University contributes. PERS members receive a similar benefit through PERS. This insurance does not provide a long-term disability or coverage for dependents.

EMPLOYER PAID NONINDUSTRIAL DISABILITY INSURANCE (NDI) PLAN A AND PLAN B

Nonindustrial Disability Insurance is provided free to all employees who are regular members of a basic retirement system to which the University contributes. NDI provides protection against loss of income from illness or accident not connected with employment. Two NDI Plans are offered. Plan A or Plan B.

Plan A: Provides 50% of salary up to $125 per week for 26 weeks. Benefits begin after 7-day waiting period (waived if hospitalized); exhaustion of sick leave (up to 90 days); or when salary stops, whichever is later.

Plan B: Provides 70% of salary up to $1500 per month for 52 weeks. Benefits begin after 365-day waiting period; exhaustion of sick leave; or when salary stops, whichever is later.

Enrollment in Plan A is automatic unless you voluntarily selected Plan B.

You may transfer from Plan A to Plan B at any time. You may only transfer from Plan B to Plan A during an announced open enrollment period. You may also enroll in the Short Term Disability Supplement at that time, but enrollment is subject to a pre-existing conditions limitation and a deferred effective date.

Employees who selected Plan B are not eligible for the STD Supplement insurance because Plan B benefits are approximately equivalent to combined Plan A and STD Supplement benefits.

IMPORTANT

This personalized Summary of Insurance Benefits has been prepared on certain assumptions:

- The provisions of the insurance policies will always govern in the event there is any discrepancy with the details of this statement. The summary is based on records on file, and though every effort has been made to attain accuracy, the right to correct any errors reported must be reserved.
- Although it is the intent to continue these plans indefinitely, the right to modify, amend or to discontinue insurance plan benefits in the future must be reserved.