

AFFIDAVIT OF JAMES Michael PETERS
(Legal Name of Candidate)

State of Florida, County of Pasco

BEFORE ME, the undersigned authority, personally appeared JAMES Michael PETERS, who being first duly sworn or placed under affirmation, says:

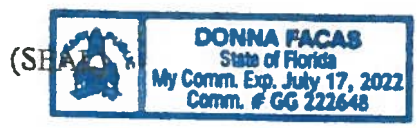
1. My legal name is JAMES MICHAEL PETERS. I am over the age of eighteen (18) and the contents of this affidavit are true and correct.
2. I am a candidate for the office of CITY COUNCIL MEMBER.
3. My nickname is MIKE PETERS. I am generally known by this nickname or have used it as part of my legal name. I have not created the nickname to mislead voters. I plan to designate this nickname on my candidate oath as the name I wish to have printed on the ballot when I submit the candidate oath form during the qualifying period for the above office.
4. Attached are 4 documents that show that my nickname is one by which I am generally known or is one that I have used as part of my legal name: JAMES MICHAEL PETERS

Further, affiant sayeth not.

[Signature]
Signature of Affiant

JAMES MICHAEL PETERS
Printed/Typed Name of Affiant

Sworn to and subscribed before me this 9 day of FEB, 20 21
by JAMES MICHAEL PETERS



[Signature]
Notary Public
DONNA FACAS
Printed Name

Personally known or Produced Identification

Type of Identification Produced Self



Print Date: 04/17/2018

True Focus Eye Care, P.A.

8319 Embassy Blvd.
Port Richey, Florida 34668-6449
Phone: 727-819-0440 FAX: 727-819-9795

Exam Date: 04/17/2018
Expiration Date: 04/17/2019

Final Contact Rx (Monovision)

Patient: Mike Peters

6446 River Road
New Port Richey, FL 34652

RT:

Qty: 0

Product	BC	Dia	Sphere	Cylinder	Axis	Add	Tint
BIOFINITY	8.60	14.00	+4.00	SPH.			Clear

LT:

Qty: 0

Product	BC	Dia	Sphere	Cylinder	Axis	Add	Tint
BIOFINITY TORIC	8.70	14.00	+4.00	-1.25	080		Clear

Wear Schedule

Daily

Replenishment

Monthly

DOT

NONE

Care Regimen

DISINFECTION: Optifree.

Notes

Provider:


Mark Wilcox Mathews III O.D.

License #: OPC 1388

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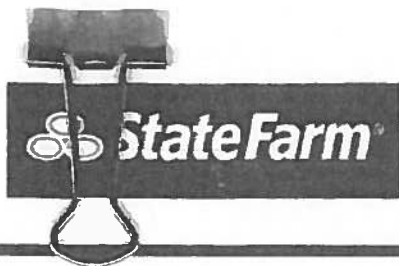
Mark Wilcox Mathews III License#: OPC 1388

RT : BIOFINITY

BC	Dia.	Sph.	Cyl.	Axis	Add	Prism
8.60	14.00	+4.00	SPH.			

LT : BIOFINITY TORIC

BC	Dia.	Sph.	Cyl.	Axis	Add	Prism
8.70	14.00	+4.00	-1.25	080		



Statement Date: January 1, 2021

 **State Farm Benefits Resource**
www.statefarmbenefits.com

 V034556

MIKE PETERS
6446 RIVER ROAD
NEW PRT RCHY FL 34652

Quarterly Account Statement State Farm 401(k) Savings Plan



State Farm 401(k) Savings Plan	
Account Summary	10-01-2020 to 12-31-2020
Opening Balance	\$304,914.51
Deposits	\$0.00
Withdrawals	\$0.00
Fees/Expenses	\$0.00
Gains/Losses	\$37,127.31
Closing Balance	\$342,041.82
Vested Balance	\$342,041.82
Your Personal Rate of Return	12.18%

Scan here to see up-to-date account details on the benefits site.



Contributions and Earnings



 You	\$175,511.28	51%
 Employer	\$166,530.54	49%
Total	\$342,041.82	100%



ALIGHT SOLUTIONS BPS
 PO BOX 7109
 RANTOUL, IL 61866-7109

MDG2021 00009828 01



MIKE PETERS
 6446 RIVER RD
 NEW PRT RCHY FL 34652-2224



<input type="checkbox"/> CORRECTED (if checked)		OMB No. 1545-0119 2020 Form 1099-R		Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.			
1 Gross distribution \$ 4186.08		2a Taxable amount \$ 4186.08		2b Taxable amount not determined Total distribution			
3 Capital gain (included in box 2a) \$			4 Federal income tax withheld \$				
PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and phone no. ALIGHT SOLUTIONS BPS STATE FARM RETIREMENT PLAN PO BOX 7109 RANTOUL, IL 61866-7109							
PAYER'S TIN 20-2387942				RECIPIENT'S TIN 866-935-4015			
RECIPIENT'S name, street address, (including apt. no.), city or town, state or province, country, and ZIP or foreign postal code MIKE PETERS 6446 RIVER ROAD NEW PRT RCHY, FL 34652							
Account no. (see instruction)							
5 Employee contributions/ Designated Roth contributions or insurance premiums \$		6 Net unrealized appreciation in employer's securities \$		7 Distribution code(s) 7		IRA/ SEP/ SIMPLE <input type="checkbox"/>	
8 Other \$		9a Your percentage of total distribution %		9b Total employee contributions \$			
10 Amount allocable to 1099-R		11 1st year of distribution		12 CATCA Plan			

<input type="checkbox"/> CORRECTED (if checked)		OMB No. 1545-0119 2020 Form 1099-R		Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.			
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Cigna Dental
 Cigna Health and Life Insurance Company
 P.O. BOX 188037
 CHATTANOOGA, TN 37422

THIS IS NOT A BILL



MIKE PETERS
6446 RIVER ROAD
NEW PRT RCHY, FL 34652-2224

FOR CUSTOMER SERVICE:
1.800.Cigna24 (1.800.244.6224)
 or visit www.myCigna.com

Please have your patient ID (U0894895550) or the employee's social security number available when calling Customer Service, visiting your health care professional, or writing to us.

Your explanation of dental benefits (for the claim processed on Mar 28, 2017)

Your current account summary

\$50 has been applied towards your \$50 individual deductible
 \$50 has been applied towards your \$150 family deductible
 \$166.40 has been applied towards your \$1,200 individual maximum
 \$0 has been applied towards your \$1,000 lifetime ortho maximum

The balances shown above are as of Mar 28, 2017, the day the claim was finalized. However, the balances on the website are updated daily, so the balances shown here may not match those listed on your participant website at myCigna.com.

Your payment summary

Paid to: WEST COAST DENTAL
 PARTNERS PL
 Amount: \$166.40

Did you know that your overall health can be impacted by your oral health?

Did you know that your oral health and certain medical conditions are closely associated? Aspects of your oral health can even affect your overall well being. Go to myCigna.com for information on the oral and overall connection and for tools you can use today to take your health and wellness into your own hands.

Your claim details

PATIENT NAME: **MIKE PETERS** CUSTOMER NAME: MIKE PETERS
 HEALTH CARE PROFESSIONAL NAME: WEST COAST DENTAL PARTNERS PL GROUP NAME: STATE FARM INSURANCE COMPANY GROUP #:
 DOCUMENT
 PROCESSED DATE: Mar 28, 2017

AMOUNT YOUR HEALTH CARE PROFESSIONAL CHARGED (\$)	YOUR HEALTH CARE PROFESSIONAL'S CONTRACTED AMOUNT (\$)	AMOUNT ELIGIBLE FOR COVERAGE BY YOUR PLAN (\$)	YOUR DEDUCTIBLE (\$)	REMAINING BALANCE (\$)	YOUR PLAN COVERED	
					(%)	(\$)
For service on Mar 15, 2017: Periodontal Maintenance (Cleaning)* (see note DG)						
129.00	77.00	77.00	0.00	77.00	100%	77.00
For service on Mar 15, 2017: 4 Bitewing X-rays* (see note DG)						
59.00	32.00	32.00	0.00	32.00	100%	32.00

Continued

* Current Dental Terminology © American Dental Association

GD5001A 0009936