FOX VALLEY LABORERS HEALTH AND WELFARE FUND

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OVER THE COUNTER COVID-19 TESTING KITS REIMBURSEMENT CLAIM FORM

For use effective January 15, 2022 through the end of the COVID-19 Public Health Emergency

NAME: _____ **SSN or FVL:** _____

ADDRESS: _____

_____

TELEPHONE NO: _____

PATIENT NAME: _____

RELATIONSHIP: _____ **SSN:** _____

Over-the-Counter COVID-19 Rapid Home Testing Kit Attestation Statement

I _____[print full name of Participant], hereby attest that the over-the-counter COVID-19 rapid home testing kit(s) I purchased on _____[enter date(s)] for either myself and/or my dependent(s) who are currently enrolled and eligible in the Fox Valley Laborers Health and Welfare Fund were purchased for personal diagnostic testing use only. In addition, I hereby attest the testing kit(s):

(1) were not purchased as a condition of employment or for employment purposes;
(2) have not been, and will not be, financially reimbursed by another source;
(3) will not be for use by any individual other than myself or my dependents who are enrolled in the Plan; and
(4) will not be re-sold to a third-party.

I do hereby attest that this information is true, accurate and complete to the best of my knowledge, and I understand that any falsification of material fact may subject me to full repayment of such reimbursed testing kit(s) to the Plan.

Attached to this document is my receipt showing proof of purchase, including purchase date and price, and the UPC barcode(s) for the testing kit(s).

_____
Printed Name of Plan Participant

_____ _____
Signature of Plan Participant Date Signed

See reverse side for important notes

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PLEASE NOTE:

- Only purchases made on or after January 15, 2022 are eligible for reimbursement.
- You must attach itemized register receipts for each eligible purchase. The receipt must show the store name, date of purchase, name of testing kit, and purchase price. Sales tax will be reimbursed. Shipping charges will not be reimbursed.
- You must remove the UPC barcode found on the testing kit boxes and submit with this claim form from all testing kit boxes being submitted for reimbursement.
- Each covered individual can submit their reimbursement for up to eight (8) at-home COVID-19 testing kits per month.
- You must complete one claim form for each patient, for each submission.
- Keep copies of your receipts and UPC barcodes for your records as they will not be returned.
- Electronic claims submission will not be accepted.
- Patient must be eligible under the Welfare Plan at the time the expense is incurred.
- This reimbursement does not apply toward the annual Family Supplemental Benefit.