**Central Laborers' Welfare Fund**
PO Box 1267
Jacksonville, IL 62651-1267

# OTC At Home COVID-19 Test Reimbursement Form

**[1-800-252-6571] – Phone**
**[1-217-243-8619] – Fax**
**[claims@central-laborers.com] - email**

☐ Check this box if your address has changed

**This form is only to be used to request reimbursement for COVID-19 tests paid for out of your own pocket.**

| Name (Last & First Name) | | | | ID # |
|---|---|---|---|---|
| Address | City | State | Zip Code | Telephone No. |
| Email Address | | | | |

| Name of Merchant | Name of the test | Name of Claimant (Must be covered under this Health Plan) | Date of Purchase | Number of Tests | **Total Expense Amount** |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | TOTAL | |

## ***CERTIFICATION FOR REIMBURSEMENT***

***Effective for purchases made on or after January 15, 2022.***

***Reimbursement is limited to 8 tests per covered member per month.***

***Receipts are required for reimbursement. Reimbursements submitted without a receipt will be denied.***

I attest by signing this form that the OTC COVID-19 test was purchased by the participant, beneficiary or enrollee for personal use, not for employment purposes, and has not been (and will not be) reimbursed by another source and is not for resale.

Any person who knowingly and with intent to injure, defraud, or deceive, files a statement of claim containing false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

**Participant Signature** ______________________________ **Date** ______________

**SIGNATURE IS REQUIRED FOR REIMBURSEMENT.**