

**RAILROAD MAINTENANCE  
AND INDUSTRIAL HEALTH  
AND WELFARE FUND**

**OTC At Home COVID-19 Test  
Reimbursement Form**

<input type="checkbox"/>	Check this box if your address has changed
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**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 Claimant (Must be covered under this Health Plan)	Date of Service	Number of Tests	Total Expense Amount
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
TOTAL				

**PARTICIPANT'S CERTIFICATION FOR REIMBURSEMENT**

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

***Reimbursement is limited to 8 test kits per covered member per month.***

***Itemized Receipts are required for reimbursement.***

<p>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.</p> <p>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.</p>
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**Participant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

SIGNATURE IS REQUIRED FOR REIMBURSEMENT

**RETURN FORM TO: Railroad Maintenance and Industrial Health and Welfare Fund  
2725 W. Monroe Street, Springfield, IL 62704**