RAILROAD MAINTENANCE AND INDUSTRIAL HEALTH AND WELFARE FUND

OTC At Home COVID-19 Test Reimbursement Form

☐ 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 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.

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

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