



INDIANA LABORERS WELFARE FUND

P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587

Telephone (812) 238-2551 Toll Free 1-800-962-3158

Fax (812) 238-2553 www.indianalaborers.org

OVER-THE-COUNTER COVID-19 TEST COVERAGE ATTESTATION FOR CLAIMS ON OR AFTER JANUARY 15, 2022

Participant Name: _____

ID#: _____

Purchaser Name: _____

Purchased for use by (Name): _____

Over-the-Counter COVID-19 test was purchased for the following reason:

☐ employment purposes ☐ personal use ☐ educational (school) purposes

☐ other, please explain _____

____ I attest the Over-the-Counter COVID-19 test(s) was/were purchased by a covered person under this Plan for personal use.

____ I attest the Over-the-Counter COVID-19 test(s) was/were NOT purchased for employment, educational or other purposes.

____ I attest the Over-the-Counter COVID-19 test(s) has/have NOT been and WILL NOT be reimbursed by another source (including but not limited to other insurance coverage or FSA, HSA, HRA).

____ I attest the Over-the-Counter COVID-19 test(s) has/have NOT been and WILL NOT be used for resale or transferred to a non-covered person.

Participant Signature

Date

Dependent Signature (if age 18 or over)

Date

Please attached proof of purchase to this claim form.

Officers-Board of Trustees

James O. McDonald, II
Chairman

David A. Frye
Secretary-Treasurer

Somer Taylor
Administrative Manager

