INDIANA LABORERS WELFARE FUND

P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free (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

Francis J. Gantner
Chairman

David A. Frye
Secretary-Treasurer

Somer Taylor
Administrative Manager