INDIANA LABORERS WELFARE FUND

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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

_____ 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 or educational 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 attach proof of purchase to this claim form.