WISCONSIN LABORERS' HEALTH FUND
4633 LIUNA WAY, SUITE 201, DE FOREST, WI 53532-2514 ~ PHONE: 608-842-9101

Over-the-Counter (OTC) COVID-19 Test Kit Reimbursement Form (NOT for HRA Reimbursements)

For eligible OTC COVID-19 tests purchased on/after January 15, 2022 during the U.S. COVID-19 public health emergency

Participant Information

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Participant's Name - Please Print *ID Number*

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Address *City* *State* *Zip Code*

Attach **receipts and UPC labels** for each FDA-approved, cleared or authorized OTC COVID-19 test kit expense listed below when submitting form. Credit card statements, canceled checks, estimated expenses, etc. are not valid documentation. Please see your Summary Plan Description for more details on the claims process. **The total benefit is limited to 8 individual OTC COVID-19 tests per covered person per month (a test kit package with 2 tests = 2 individual tests).**

You must complete all fields below and submit receipts and UPC labels from test kits for reimbursement.

	Purchase Date	Retailer (you must submit receipt)	UPC Code on Package (you must submit package's UPC label)	Number of Tests in Package	Covered Person to be Tested (full name and relationship)	Purchase Price
Test Kit #1						$
Test Kit #2						$
Test Kit #3						$
Test Kit #4						$
Test Kit #5						$
Test Kit #6						$
Test Kit #7						$
Test Kit #8						$
Attach additional pages if necessary.					**Total Reimbursement Claim**	$

Participant Attestation By signing below, I attest that all OTC COVID-19 test kits for which reimbursement is requested on this form:

1. Were purchased while I was eligible for Plan coverage, on or after January 15, 2022, and during the COVID-19 public health emergency declared by the Secretary of the U.S. Department of Health and Human Services (HHS);
2. Were for personal use by me or my dependents who were covered by the Plan at the time of purchase;
3. Were not purchased as a condition of employment or for employment purposes;
4. Have not been otherwise paid for or reimbursed, nor will they otherwise be reimbursed, through any other source, including my HRA;
5. Will not be re-sold.

I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and **any falsification of material fact or breach of the above attestations may subject me to full repayment of such reimbursed testing kit(s) to the Plan and may result in my loss of coverage under the Plan.** I understand the reimbursement is not deducted from my HRA.

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Participant's Signature *Date*