IUOE Local No. 478 Health Benefits Fund

CERTIFICATION FOR REIMBURSEMENT OF FDA-APPROVED OVER-THE-COUNTER COVID-19 TESTS PURCHASED ON OR AFTER JANUARY 15, 2022 ONLY

CERTIFICATION. I, _____ (*print your name*), hereby certify to the IUOE Local No. 478 Health Benefits Fund (Fund), that with respect to any FDA-approved over-the-counter COVID-19 tests ("Tests") that I and/or my covered dependent(s) purchased on or after January 15, 2022 for which reimbursement is sought from the Fund, all of the following representations are true and correct:

- ✓ The Tests were purchased for personal use, and
- ✓ The Tests are **not**, and were **not**, for employment purposes, and
- ✓ The Tests have **not** been, and will **not** be, reimbursed by any other source, and
- ✓ The Tests are **not** for resale to any other individual(s) or entities.

If you are the covered dependent (i.e. spouse or child) of an Active Member or Retired Member (whether pre-65 or Medicare), indicate such IUOE Local 478 Member's name here for verification purposes: _____.

Please be aware that the Fund reserves the right to request additional relevant information from you, or the Active or Retired Member, in connection with any reimbursement request for these Tests.

ACKNOWLEDGEMENT. I acknowledge that this Certification is being submitted for the purpose of determining my and/or my covered dependent(s) eligibility for health and related benefits under the Fund's rules, as well as for any associated reimbursement from the Fund. I also acknowledge that I am signing this Certification under penalties of making a false statement.

By (SIGN):_____ Dated:_____

Print Name: _____

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PLEASE ATTACH COPIES OF ALL ASSOCIATED DETAILED RECEIPT(S) FOLLOWING THE INSTRUCTIONS ON THE FUND'S OTC COVID TESTS NOTICE, AND PROVIDE THE FOLLOWING INFORMATION:

(1) How many total **Tests** are you requesting reimbursement for*? _____
(* - note there is reimbursement limit of 8 Tests per covered individual, per calendar month. Some Tests are sold in packages or kits with more than one test, the Fund counts each TEST separately.)

(2) What is the total amount* of reimbursement you are requesting? $_____
(* - note that the Fund reimburses only for the actual cost of the Test, and not for additional amounts such as taxes, shipping and/or handling charges, express mail fees or costs, etc.)

(3) What is the brand of test you purchased so the Fund can ensure it is FDA approved: _____

(4) What is the date you purchased the test? Please note it must be on and after 1/15/2022: _____

(5) Please provide your address and phone number in the event the Fund needs to contact you:

Telephone / Cell: _____

Address: _____

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