CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND Reimbursement Form Over the Counter (OTC) COVID-19 Tests	Both sides of this form is to be completed by the participant for OTC COVID-19 test purchased on or after January 15, 2022, for eligible participants and their dependents. Mailing Address: Central PA Teamsters HW Fund, P.O. Box 15224, Reading, PA 19612-5224 Electronic Transmissions: hwfund@centralpateamsters.com Fax: 610-320-9236 **IMPORTANT! All claims must be submitted within 1 year, to insure payment.**

Name of Participant: Identification No: CPT

Address Street	City	State	Zip Code	Email: Phone: ( )

Sex	Age	Member of Local Union No.	Employer	Job Classification

Do you have any other Group Health ins.? No □ Yes □ If yes, give name of carrier___________________________________ Carrier Phone No. ( ) Eff date:	Does your spouse have any other Group Health Ins? No □ Yes □ If yes, give name of carrier: ______________________________ Carrier Phone No. ( ) Eff Date:
Do you or your family have any other Non-Group Health Insurance? No □ Yes □ If yes, give name of carrier___________________________________ Phone No. ( ) Eff date:	If yes above, what is the type of coverage did your spouse elect? Single □ Family □ Other □ Does this insurance provide an HSA? No □ Yes □ Does this insurance provide an HRA? No □ Yes □

DEPENDENT INFORMATION

Name of Dependent	Relationship	Sex	Birthdate
Does Dependent Work? No □ Yes □; *If yes, do they have any other Group Ins?* No □ Yes □ *Carrier name:* *Carrier Phone No. ( )* *Eff Date:*		Employer Name: Phone No. ( )	

Eligible participants and dependents, where the Fund is the primary insurance, can seek reimbursement for FDA authorized, cleared, or approved OTC COVID-19 test on or after January 15, 2022, for their own personal use. The Fund will reimburse a maximum of 8 individual tests per eligible participant/dependent every 30 days. The Fund will not provide reimbursement for additional tests purchased prior to the end of the 30-day period.
Documentation required for reimbursement: (Please complete the reverse side of this form)

- Participant signed reimbursement form;
- An itemized receipt including proof of purchase;
- Date of purchase;
- Price of the OTC COVID-19 test; and
- The product UPC code and number of tests in the pack.

RELEASE: I attest that by signing this form that the OTC COVID-19 test was purchased by the participant, beneficiary, or enrollee for personal use, not for employment purposes, and has not been (and will not be) reimbursed by another source and is not for resale. Any person who knowingly and with intent to injure, defraud, or deceive, files a statement of claim containing false, incomplete, or misleading information may be guilty of a criminal act punishable under law. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signed ____ Date ________________

(Must Be Signed by Participant Only)

-OVER-

FIRST NAME:	UPC CODE:	# Test in Kit:	DATE:	PD AMOUNT:
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FDA authorized, cleared, or approved OTC COVID-19 Antigen tests include, but are not limited to:

- BINAXNOW COVID-19 AG SELF TEST
- CARESTART COVID-19 AG HOME TEST
- ELLUME COVID-19 HOME TEST
- FLOWFLEX COVID19 AG HOME TEST
- IHEALTH COVID-19 AG RAPID TEST
- QUICKVUE AT-HOME COVID-19 TEST