SHEET METAL WORKERS LOCAL 98 WELFARE FUND
ADMINISTRATION OFFICE
3150 U.S. Route 60 * ONA, WV 25545 * (304) 525-0331 * (304) 525-6005 FAX

OTC COVID TEST REIMBURSEMENT FORM

The Plan will reimburse the cost of eligible over-the-counter COVID 19 tests purchased by a participant. The following parameters apply:

- Each individual covered under the Plan may be reimbursed for up to 8 tests per calendar month.
- If the test kit contains more than one test, each test in the kit counts towards the 8-test monthly maximum.
- A receipt dated January 15, 2022 or later, must be provided documenting the purchase of the test.

Member Name _____ Telephone Number _____ Member ID# _____

Address _____ City _____ State _____ Zip Code _____

Names of Dependents Covered under the Plan _____

Reimbursement Request:

Date of Purchase	Total Number of Tests If kit contains more than one test, you must report each test in the kit	Member/Dependent for Whom Test was Purchased	Cost
			$
			$
			$
			$
			$
			$

Should you require more space, please attach an additional page

As a condition of reimbursement, you must agree to each of the following statements:

- ☐ The test(s) were purchased for personal use and not for employment testing purposes
- ☐ Participant will not be reimbursed for test(s) from another source
- ☐ The test(s) will not be resold

Signature: _____ Date: _____