Health & Welfare Fund H&W LOCAL 399

ELITE
Administration & Insurance Group, Inc.

OVER-THE-COUNTER FDA AUTHORIZED COVID-19 TESTING ATTESTATION

Please check the following statements and return this attestation form as quickly as possible. **You MUST submit this form to the Funds Claims Administrator to be eligible for reimbursement for the purchase of an over-the-counter ("OTC") FDA Authorized COVID-19 testing kit(s).**

CLAIMS ADMINISTRATOR:
Elite Administration
1300 W. Higgins Road • Suite 208
Park Ridge, IL 60068

☐ I purchased the OTC FDA Authorized COVID-19 testing kit(s) on _____ / _____ / _____ *(enter date)*.

☐ My ID Number is: _____ *(enter ID from your BCBS ID Card)*.

☐ I purchased the OTC FDA Authorized COVID-19 testing kit(s) for myself and/or my eligible Dependent(s) under the Welfare Plan. If on behalf of an eligible Dependent(s), please identify the Dependent(s):

Dependent(s) Name(s): _____

Dependent(s) Name(s): _____

☐ I purchased the OTC FDA Authorized COVID-19 testing kit(s) for diagnostic use only and **NOT** for the purposes of employment.

☐ I have not been, and will not be, financially reimbursed for the purchase of the OTC FDA Authorized COVID-19 testing kit(s) by any another source *(example FSA)*.

☐ I will not re-sell the OTC FDA Authorized COVID-19 testing kit(s) to a third-party.

I, the undersigned, hereby certify that the above statements are true, complete, and accurate to the best of my knowledge and belief. I understand that any falsification of the above statements may require that I return repayment of any reimbursed testing kit(s) to the Welfare Fund.

☐ I have attached an itemized receipt to this attestation form, which shows proof of purchase of the testing kit(s) and includes the seller's name and date of purchase.

Participant's Signature: _____ Date: ____ / ____ / _____

Print Name: _____ Phone Number: (_____) _____