United Food & Commercial Workers
Union-Employer Health and Welfare Fund
9199 Market Place, Suite 1
Broadview Heights, OH 44147

Statement of Claim for reimbursement and Attestation
(Not for Employment purposes or other purposes such as admission to events)
for OTC (Over the Counter) Covid-19 Test
Limit 8 tests per Member household per calendar year

1. Print Last Name	**First Name**	**Middle Initial**
2. Home Address		
3. City	**State**	**Zip Code**
4. Birthdate month/day/year		**Social Security Number**

By signing below, I attest that the purchased OTC Covid-19 tests for which I am seeking reimbursement for myself or my dependent are for personal use, and I will not use any such test for employment purposes or admission to events such as sporting events or concerts, and the tests will not be reimbursed by another source. I further attest that I will not offer these tests at any time for resale.

Member Signature Date

All Claims must be accompanied by the ORIGINAL DATED store receipt, the UPC from the test package AND the part of the package which lists how many tests are contained in the package. Photocopies are NOT acceptable and will be rejected. Please mail or bring with this form to Fund Office Address noted above.