PIPEFITTERS WELFARE FUND, LOCAL 597
OVER THE COUNTER COVID TEST CLAIM FORM

Phone (312) 633-0597 - Fax (312) 829-7787
www.pf597.org

Member's Name _____
First Last Phone Number

Address _____
Street City State Zip Code

_____ or _____
Soc. Sec. Number U.A. Card Number Date of Birth

Effective January 15, 2022 up to 8 FDA Approved Over the Count (OTC) COVID Tests can be reimbursed per family member covered by the Plan per calendar month. Please complete the information below and include your "Itemized" receipt(s) for all tests.

Date Test(s) Purchased	Name of Family Member Test(s) Purchased For	Number of Tests Purchased	Cost Per Test	Total Expense for Family Member
		Total Requested Reimbursement Amount		

This is to certify that my statements on this Claim form are complete and true. I certify that the COVID-19 tests I purchased are not for employment purposes and are for personal use only for myself, my spouse, or eligible dependents and such expenses have not and will not be reimbursed under any other Health Reimbursement Account, insurance plan, nor be claimed as an income tax deduction, nor be sold to a third party.

PLEASE NOTE - IT MAY TAKE UP TO 8 WEEKS TO PROCESS YOUR CLAIM.

Member's Signature Date