410 Chickamauga Ave
Suite 301
Rossville, GA 30741

NECA FMCP
Family Medical Care Plan

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OVER-THE-COUNTER (OTC) COVID TEST REIMBURSEMENT REQUEST FORM

Participant's Full Name: _____

Group #: _____ **Member ID #:** _____

Address: _____ **Email:** _____

_____ **Telephone:** _____

Proof of purchase with 1) a description of eligible expense; 2) date of purchase; and 3) amount to be reimbursed must be included with this form in order to receive reimbursement.

Description of Eligible Expenses Incurred	Amount	Name of Participant (Member, Spouse, or Eligible Dependent) Who Incurred Expenses	Date of Birth of Participant	Does the Participant have Other Health Insurance coverage?
1.				
2.				
3.				
4.				
5.				

ATTESTATION

I certify that all claims for reimbursement listed on this Form were purchased by me for personal use and **not** for *any employment-related purposes*. I further certify that these expenses have not been and will not be reimbursed by another third party and are not for resale. I attest this information is true and correct and that failure to provide true and accurate information on this Form may result in the Plan taking any legal action available - including a reduction in benefits - against me, my dependents, and/or any third party.

_____ _____

Member or Spouse Signature **Date**

Once you completed this Form, you can mail it to the Benefit Office at the address above. Be sure to include any and all receipts related to your expense reimbursement request. If you have any questions, please contact the Benefit Office.

Please allow at least **60 days** from the date of submission of this reimbursement request form to receive your reimbursement check.