HOMECARE WORKER
Supplemental Trust

Providing Benefits to Oregon Homecare and Personal Support Workers

Affidavit Regarding Benefit Convenience Card Use

Please sign this affidavit below and return it to the Oregon Homecare Workers Supplemental Trust office.

I, _____, by my signature below, certify that I will use the Benefit Card ("Card") issued to me through Ameriflex by the Oregon Homecare Workers Supplemental Trust ("Trust") only to pay for medical and prescription drug copays, deductibles and co-insurance expenses related to claims covered by my Trust-Approved Plan or Medicare plan provided the claims were incurred while I was eligible for Trust benefits.

I also certify that I will use the Card only to pay the medical expenses listed above and premium amounts covered under the Trust for: (a) goods that I purchase solely for my own use; and (b) services that are provided directly and solely to me.

I understand that I am obligated to promptly provide to the Card Administrator, Ameriflex, documentation of the expenses charged to my card so that the Trust can verify that the expenses are covered under the Trust. I understand that if my Card is used to pay for any expense not covered under the Trust, I will be obligated to immediately reimburse the Trust for any such expenses and my Card will be revoked.

I understand I can find more information about the Card and the terms used in this letter in my Plan Booklet, the Benefit Convenience Card Frequently Asked Questions or by visiting the Trust website at https://www.orhomecaretrust.org/resources/#medical.

_____ _____

Participant Signature Date

Legal Name (Last, First, MI): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

[Revised October 2018 | 9OE1030v2]