



**Flexible Spending Account Health Care Reimbursement Account
Employee Affidavit of Lost/Stolen Independent Third Party Documentation**

Send completed form to:

**Aetna
P.O. Box 14586
Lexington, KY 40512-4586**

1. Employee Information	Identification Number	Name	Daytime Telephone Number ()
	Address (include zip code) <input type="checkbox"/> Check if address is new		Home Telephone Number ()
2. Employer Information	Employer Name		FSA Control Number

I certify that the health care expenses submitted on the enclosed/attached Flexible Spending Account (FSA) Health Care Reimbursement form are for expenses incurred that have not been reimbursed or are not reimbursable under any other health care coverage (including a Health Savings Account [HSA] that I or my spouse maintains. I understand that a health FSA may reimburse a medical expense only if the participant provides a written statement or explanation of benefits from an independent third party stating that the medical expense has been reimbursed or is not reimbursable under any other health plan coverage.

I also certify that it is impossible to provide the applicable independent third party documentation because it was either lost or stolen as a result of a casualty (for example, hurricane, flood, fire) or theft, and to the best of my knowledge and belief, all information on the enclosed/attached Flexible Spending Account (FSA) Health Care Reimbursement form is true, complete, correct and made in good faith.

Sign Here ► Employee's Signature _____ Date _____