aetna®

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

Send completed form to:
Aetna, Inc.
PO Box 981106
El Paso, TX 79998-1106
Fax to: 1-859-455-8650 (within USA)
1-859-425-3370 (outside USA)
Telephone: 1-800-255-2386
If overseas, 210-366-2416 (collect)

1. Employee Information	Identification Number	Name	Daytime Telephone Number ( )
	Address (include ZIP Code) ☐ Check if address is new		Home Telephone Number ( )
2. Employer Information	Employer Name **ExxonMobil**		FSA Control Number **721002-010-000**

I certify that the dependent care expenses submitted on the enclosed/attached Flexible Spending Account (FSA) Dependent Care Reimbursement form are for expenses incurred and that I have not and will not claim credit for these expenses on my individual income tax returns. I understand that a dependent care FSA may ordinarily reimburse qualifying dependent care expenses only if:

- the participant provides a written statement from an independent third party stating that the dependent care expenses are for care of a qualifying child or relative and do not include separate charges (for example, food, clothing, education, etc.) as outlined within the "Employee/Caregiver Certification" section of the Flexible Spending Account (FSA) Dependent Care Reimbursement claim form and
- the caregiver's information (name, address, Social Security or tax ID number) is provided on the Flexible Spending Account (FSA) Dependent Care Reimbursement claim form or an attached receipt that has been prepared by the care provider.

I also certify that it is impossible to provide the applicable independent third party documentation and/or caregiver's information because:

- it was either lost or stolen as a result of a casualty (for example, hurricane, flood, fire,) or theft and
- I cannot, having made a good faith attempt, contact the caregiver to obtain the required caregiver's information (name, address, Social Security or tax ID number of Caregiver) due to circumstances beyond my control. Examples of such circumstances may be death of the provider, or inability to locate the provider because he or she was displaced as a result of a natural disaster.

I also certify that, to the best of my knowledge and belief, all information on the enclosed/attached Flexible Spending Account (FSA) Dependent Care Reimbursement form is true, complete, correct and made in good faith.

Sign Here ► Employee's Signature _____ Date _____