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aetna®

ExxonMobil Pre-Tax Spending Plan
Health Care Flexible Spending Account Claim Form

- Complete Sections 2 - 4.
- Submit the following supporting documentation with this request:
  - Explanation of Benefits (EOB) statement indicating amounts paid by the medical or dental plan. For HMO's, submit evidence of payment only.
  - Copy of proof of payment or copayment receipt from the provider when the copayment is your only cost and you do not receive an Explanation of Benefits statement (EOB).
  - Itemized bills or receipts from the doctor, dentist, or other supplier for expenses **not covered** by your Medical/Dental Plan(s). Documentation must include: Provider's name, patient's name, date(s) of service, description of service or supply, and amount charged. **A cancelled check is not adequate documentation.**
- If the expense is not covered by any plan, send a note explaining that the expense is not covered along with bills.
- Retain copies of this form and your supporting documentation. Documentation submitted with this form will not be returned.
- If your claim submission is for more than three family members, please submit a separate claim form for the additional family members.
- Call Aetna's Automated Voice Response Unit at 800-255-2386 to get instant account balance and claim payment information from 8:00 a.m. to 9:00 p.m. ET.
- **Items for which you are reimbursed cannot be claimed as deductions or credits on your federal income tax returns.**
- **Send the completed claim form and documentation to the Aetna office:**

  Aetna, Inc.
  PO Box 981106
  El Paso, TX 79998-1106

  Fax to:
  1-859-455-8650 (within USA)
  1-859-425-3370 (outside USA)
- **If you have questions about a claim, call Aetna at 1-800-255-2386. Overseas, call 210-366-2416 (collect). Hours 8:00 a.m. to 6:00 p.m. CT.**

1. Plan Information	**ExxonMobil Pre-Tax Spending Plan**			FSA Control Number **721002**
2. Employee Information	Member ID Number or Social Security Number	Name		Daytime Telephone Number ( )
	Address (include ZIP Code)			Home Telephone Number ( )
3. Patient Information	Name ____________	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From ________ Thru ________		**Total Amount Submitted** $ ________	
	Name ____________	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From ________ Thru ________		**Total Amount Submitted** $ ________	
	Name ____________	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From ________ Thru ________		**Total Amount Submitted** $ ________	
	Reimbursement will not be made unless appropriate documentation is attached as explained above.			
4. Employee Certification	I certify that the above expenses have been incurred by me and/or my eligible dependents and are not payable by any other plan. I further declare that I have not and will not deduct these expenses on my federal, state, or local income tax returns. Employee Signature X ____________			Date ________