Fund Reimbursement Request
Reimburse Expenses Not Covered by the Medical and/or Dental Plan
Claim Instructions

NOTE: This form should be used to submit expenses that are only covered by the fund portion of your Aetna HealthFund® and/or Aetna DentalFund® plan and are not covered by your underlying medical or dental plan or any other medical or dental plan.

- See your employer's Summary Plan Description to determine which, if any, expenses are eligible.
- To submit expenses covered by your underlying medical plan and fund, please use the Medical Claim form on the Aetna member website.
- To submit expenses covered by your underlying dental plan and fund, please use the Dental Claim form on the Aetna member website.

You may submit a claim at any time during the year, but it is recommended that you accumulate a minimum of $50.00 in eligible expenses prior to submitting for reimbursement.

TO THE EMPLOYEE

1. Complete Sections 1 through 4. Be sure to sign the Employee Certification in Section 5.

2. Please attach the appropriate documentation. Keep in mind, a canceled check is not considered appropriate documentation. See below for details on the appropriate documentation:

   a) When submitting for Long Term Care premium reimbursement, if allowed under your Employer's plan OR when submitting for premium reimbursement for other than Long Term Care, if allowed under your Employer's plan, please submit the following documentation:
      - A statement from your insurance carrier that includes:
        - Member's name and birth date
        - Name and address of insurance carrier
        - Months in which premium expenses were incurred
        - Premium paid per month as well as total amount of paid premium

   b) When submitting for an expense for an Over-the-Counter item, if allowed under your Employer's plan, please submit the appropriate documentation which may include but is not limited to:
      - An itemized receipt from a merchant that shows the name of the product, the date purchased and the amount paid.
      - If the receipt does not show the name of the product, please submit some other proof of purchase such as a box-top or label that shows the name.

   c) If submitting an expense for other items, if allowed under your Employer's plan, either
      - An itemized bill or statement from the provider for expenses are covered by your medical and/or dental plan, which shows:
        - Name and address of provider
        - Date(s) of service and dollar amount charged
        - Patient's name
        - Type of service; or
      - Explanation of Benefits (EOB) detailing expenses that were not covered by your medical and/or dental plan.

3. Retain a copy of this form and accompanying documentation for your files.

4. **Please send the completed form and appropriate documentation to the address on the back of your Aetna HealthFund® and/or Aetna DentalFund® ID card**.

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1. Employee Information

Name (Last, First, MI)		Daytime Telephone Number ( )
Address (include ZIP Code) ☐ Check if address is new		Home Telephone Number ( )
Social Security Number	Plan you are submitting for reimbursement from ☐ Aetna HealthFund ☐ Aetna DentalFund	

2. Employer Information

Employer Name	Group Number (on ID card)

3. Expense Information – Please fill out for each member with claim activity.

Member #1	Name of Member (Last, First, MI)	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	Birth Date (MM/DD/YYYY)
Social Security Number		Identification Number (on ID card) **W**	

Date(s) of Service (MM/DD/YYYY)

From ______________ Thru ______________ Total Amount Submitted $ ______________

Or, if submitting for Premium Reimbursement for plans where premium reimbursement is allowed:

Request Premium Reimbursement for the following periods of coverage (MM/DD/YYYY)

From ______________ Thru ______________ Total Amount Submitted $ ______________

Over the Counter Product (OTC) Information (where coverage is allowed).

OTC Product Name	**Date of Purchase**	**Amount**
		$
		$
		$
	Sales Tax (where applicable)	$
	Total	$

Member #2	Name of Member (Last, First, MI)	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	Birth Date (MM/DD/YYYY)
Social Security Number		Identification Number (on ID card) **W**	

Date(s) of Service (MM/DD/YYYY)

From ______________ Thru ______________ Total Amount Submitted $ ______________

Or, if submitting for Premium Reimbursement for plans where premium reimbursement is allowed:

Request Premium Reimbursement for the following periods of coverage (MM/DD/YYYY)

From ______________ Thru ______________ Total Amount Submitted $ ______________

Over the Counter Product Information (where coverage is allowed).

OTC Product Name	**Date of Purchase**	**Amount**
		$
		$
		$
	Sales Tax (where applicable)	$
	Total	$

4. Expenses Reimbursed From Any Other Health Plan

Have you been reimbursed for these expense(s) from any other health plan? ☐ Yes* ☐ No

*If Yes, please attach to this form a copy of your member statement that outlines what the other carrier paid.

5. Employee Certification

I certify that the above information is correct and that all expenses for which reimbursement is claimed from Aetna HealthFund and/or Aetna DentalFund have been incurred by me or by an individual who is enrolled in the plan who qualifies as my spouse or my dependent under IRS guidelines, and that these expenses have not been reimbursed under any other health plan coverage (unless stated otherwise in Section 4), nor shall reimbursement be sought from any other health plan coverage, including a Health Savings Account. I declare that I have not and will not deduct these expenses on my federal, state or local income tax returns.

Employee Signature ______________________________ **Date** ______________

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Pou jwenn sèvis lang gratis, rele nimewo telefòn ki sou kat idantite ou a. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero sulla tessera identificativa. (Italian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Farsi-Persian)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić numer telefonu na Twojej Karcie Identykującej (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para o número que consta na sua identidade. (Portuguese)

Для получения бесплатной помощи переводчика позвоните по телефону, указанному на Вашей личной карточке медицинского страхования. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)