

Health & DC 37 Security Plan

AFFIDAVIT OF STOLEN/LOST DRUG I.D. CARD

Name of Member: _____

Address: _____ Apt. # _____

_____ City State Zip

Social Security #: _____

Telephone #: (Home) _____ (Work) _____

To replace a lost or stolen card, provide the information below. Sign this form before a Notary Public, have it notarized, and return it to the Prescription Drug Unit. A duplicate Prescription drug card will be mailed to you within 21 days from the date we receive this form.

The undersign swears as follows: (Please place an "X" in the appropriate box which describes the circumstances.

- I did not receive the above described I.D. card.
- I received and lost the above described I.D. card.
- I received and destroyed the above described I.D. card.
- I received the above described I.D. card, but it was stolen. Describe the circumstances giving the date and place where the card was stolen: _____

(Member's Signature)

Sworn to me this _____ day

Of _____ 20 _____

NOTARY PUBLIC

HS:DRO14/jf(Rev. 6/2000)