

Health & DC 37 Security Plan

AFFIDAVIT OF STOLEN/LOST DRUG I.D. CARD

Member's Name: _____

Address: _____ Apt. #: _____

City

State

Zip

Social Security #: _____

Home phone #: _____ Work Phone #: _____

To replace a lost or stolen card, provide the information requested 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

:jf(Rov. 6/02)

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