



FSAFEDS Program  
PO Box 36880  
Louisville, KY 40233

Fax: 1-866-643-2245 or 502-267-2233

The Estate of [Name of FSAFEDS Participant]  
c/o Executor/Executrix/Administrator of the Estate

RE: [Name of FSAFEDS Participant]

To Whom It May Concern:

Please accept our condolences on your recent loss.

As indicated on [www.FSAFEDS.com](http://www.FSAFEDS.com), if the FSAFEDS enrollee dies before the end of the Benefit Period, the account holder's surviving spouse/dependent(s) and/or estate may submit claims or receive payment for eligible expenses incurred through the account holder's date of death. Expenses incurred after the date of death are not eligible for reimbursement. In order for these reimbursements to be made, however, further information is required.

If the Estate is to be probated, benefits may be paid to the Estate of the deceased via the Executor, Executrix, or Administrator. If the Estate is not to be probated, payment may be made to Estate of the deceased in care of the individual who has assumed responsibility for handling the account holder's affairs and closing the estate. Before we can make payment, however, it will be necessary for you to complete and sign the statement on the following page, and return it to our office. Please send the requested information to the address listed at the top of this page.

Please let us again express our condolences for your loss. If you have additional questions, please contact an FSAFEDS Benefits Counselor, toll-free, at 1-877-FSAFEDS (372-3337), TTY: 1-800-952-0450, Monday through Friday, 9:00 a.m. until 9:00 p.m., Eastern Time, or via email at [FSAFEDS@shps.com](mailto:FSAFEDS@shps.com).

Sincerely,

FSAFEDS



FSAFEDS Program  
PO Box 36880  
Louisville, KY 40233

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**This letter is to notify FSAFEDS an enrollee has passed away. Please provide the following participant information.**

Name of FSAFEDS Participant: \_\_\_\_\_

Date of Death: \_\_\_\_\_

FSAFEDS Participant User ID or last 4 digits of SSN: \_\_\_\_\_

**The executor/executrix or administrator of the estate has assumed responsibility for closing the FSAFEDS participant's estate. Please provide the following information.**

Name of the executor/executrix or administrator: \_\_\_\_\_

Address of the executor/executrix or administrator: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone number of the executor/executrix or administrator: \_\_\_\_\_

As the executor/executrix or administrator, I understand that all reimbursements from the FSAFEDS account will be subject to the provisions of the FSAFEDS program.

I further understand that all reimbursements will be made to the Estate of the deceased, and will be transmitted at the referenced address.

Signature of the executor/executrix or administrator: \_\_\_\_\_

Please send the requested information to the address listed at the top of this page.