

Recurring Expense Service Form

INSTRUCTONS: This form is used to request your Individually Owned Premiums Account. Contributions will be reimbursed to you on a per pay period basis. By completing this form you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation showing the premium you will be charged throughout the year or specific time frames. **All information must be completed by you to receive reimbursement. CLAIMS WILL NOT BE PROCESSED WITHOUT YOUR SIGNATURE.**

A. Declaration of Services

I request reimbursement for the below listed timeframe for qualified Individually Owned Premium expenses.

I certify that the premiums are for coverage between the following dates:

_____ to _____
Start Date (MM/DD/YY) End Date (MM/DD/YY)

I have included copies of the insurance company's charges, which will include the total amount of:

\$ _____ for the dates provided above.
Total Amount of Services

NOTE: If you have any changes during the dates referenced above, please notify:
DataPath Administrative Services, Inc. at (877) 685-0655 or email info@idpas.com.

B. Participant Information

Name of Participant	Social Security Number		
ADDRESS Street	City	State	Zip
Phone Number ()	E-Mail		
Name(s) of Person(s) Insured			

C. Provider Information

Name of Insurance Company			
ADDRESS Street	City	State	Zip
Policy Number(s)			

D. Certification and Signature

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature _____ Date: ____ / ____ / ____

FOR FASTEST PROCESSING, FAX TO: (501) 687-3282, TOLL FREE 1-888-472-6777
Or email to info@idpas.com, or mail to: DataPath Administrative Services,
1601 Westpark Drive Suite 9. Little Rock. Arkansas 72204