REIMBURSEMENT CLAIM FORM: CREDIT CARD REIMBURSEMENT

easternhealth

SALARY PACKAGING

1: PERSONAL DETAILS

Employee Name REQUIRED	Employee Number REQUIRED
Email	Phone Number

Please note the following conditions:

IMPORTANT:

- **Credit Card benefit** claims require a copy of the bank account statement showing all credits made
- All unsigned reimbursement claim forms will not be processed and will be returned unpaid.
- All reimbursements will be made via EFT to your nominated bank account.

2: DETAILS OF EXPENSES BEING CLAIMED *(Please use the reverse side of this form if insufficient space)*

Payment Description	Payment Date	Amount Paid
	Total Claim Submitted:	$

3: BANK ACCOUNT DETAILS *(Please nominate bank account to where funds should be deposited)*

Account Name	BSB	Account Number

4: PAY DEDUCTIONS

Please nominate the number of pay periods you would like the claim to be deducted

(Please note: where you do not nominate deductions, your claim will be deducted over the least amount of pays)

Pays

5: TAXATION DECLARATION

- I declare that I understand and have complied with the above conditions.
- I declare that I have not or will not make duplicate claims for reimbursement for the same expense from Eastern Health. The receipts attached have not been and will not be used by any other person.
- I declare that the expenses as claimed on this reimbursement have been incurred by myself, partner or family member within my household.

REQUIRED	REQUIRED
Employee Signature	Date / /

OTHER BENEFITS

Date *(within 12 months of claim)*	Description of Expense	Amount Paid
	TOTAL:	$