# REIMBURSEMENT CLAIM FORM: PORTABLE DEVICES

*(Laptop, Tablets, Mobile Phones)*

easternhealth

**SALARY PACKAGING**

## 1: PERSONAL DETAILS

| | |
|---|---|
| Employee Name REQUIRED | Employee Number REQUIRED |
| Email | Phone Number |

**Please note the following conditions:**

- COPY of the tax invoice must accompany your claim
- To be eligible to claim reimbursement of a Laptop, Tablet or Mobile Phone, the item must be purchased primarily for work purposes and must be signed by your Associate Program Director, equivalent or above
- The item must be purchased outright, not on a plan
- Accessories such as bags; cases; covers or additional software or warranties will not be reimbursed
- An Administration fee of 5% of the claimed amount will be applied to each claim submitted
- Eastern Health Everyday Expenses or Entertainment Benefit Visa Cards are not to be used to purchase Portable Electronic Devices
- All unsigned reimbursement claim forms will not be processed and will be returned unpaid.

## 2: DETAILS OF EXPENSES BEING CLAIMED

| 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 to be used primarily for work related purposes.

| | |
|---|---|
| REQUIRED | REQUIRED |
| Employee Signature | Date / / |

**BUSINESS USE ENDORSEMENT**

Claim **MUST** be co-signed by your Associate Program Director / equivalent or above

| | |
|---|---|
| REQUIRED | REQUIRED |
| Employee Signature | Date / / |