Reimbursement Claim Form

# Other Benefits

easternhealth

SALARY PACKAGING

| 1. Employee Name | Employee Number |
|---|---|
| Email | Phone Number |

**Please note the following conditions:**

- **COPY** of the receipt (s) and /or paid tax invoice, evidence provided can only be backdated within 12 months
  Important:
  ***Credit Card benefit*** claims require a copy of the bank account statement showing all credits made
  ***School Fees benefit*** claims require a copy of your paid tax invoice
  ***Private Health Insurance benefit*** claims require a copy of your bank statement and copy of your policy
- 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 Date | Payment Description | Amount Paid |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | **Total Claim Submitted:** | **$** 0 |

## 3. Bank Account Details: (Please nominate bank account to where funds should be deposited)

| Bank Account Name | BSB | Account Number |
|---|---|---|
| | | |

## 4. 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.

| Employee Signature | Date |
|---|---|
| | |

C/- Eastern Health Distribution Centre 481 - 493 Maroondah Hwy Ringwood VIC 3134
p 1300 361 669 f 03 9879 8703 e salarypackaging@easternhealth.org.au

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# Other Benefits

Continued…

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SALARY PACKAGING

| Payment Date (within 12 months of claim) | Payment Description | Amount Paid |
|---|---|---|
| | | |
| | | |
| | | |