

Washington Counties Insurance Fund CLAIM FOR REIMBURSEMENT OF TRAVEL & OTHER EXPENSES



Employer Name: <input style="width:95%;" type="text"/> Address: (location where check will need to be mailed) <input style="width:95%; height: 40px;" type="text"/> Check Payable To: <input style="width:95%;" type="text"/>	Claimant Name (last): <input style="width:95%;" type="text"/> Claimant Name (first): <input style="width:95%;" type="text"/> Claimant Phone #: <input style="width:95%;" type="text"/> Period For: <input style="width:20%;" type="text"/> To <input style="width:20%;" type="text"/> <div style="text-align: right; font-size: small;">Date Date</div>
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MILEAGE **Please insure ALL expense receipts are attached when submitting this form for reimbursement.*
 Scan/Email: kathi@wcif.net | Fax: (360) 754-7859 | Mail: 2620 RW Johnson RD SW, Suite 300, Tumwater, WA 98512

DATE	FROM	TO	MILES	RATE	AMOUNT \$	PURPOSE OF TRIP
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	

MEALS & LODGING

DATE	MEALS / LODGING	PER DIEM	AMOUNT \$	PURPOSE OF MEAL / STAY
	Meals: <input style="width:20%;" type="text"/> Lodging: <input style="width:20%;" type="text"/>	\$	\$	
	Meals: <input style="width:20%;" type="text"/> Lodging: <input style="width:20%;" type="text"/>	\$	\$	
	Meals: <input style="width:20%;" type="text"/> Lodging: <input style="width:20%;" type="text"/>	\$	\$	

OTHER EXPENSES

DATE	PAID TO	AMOUNT \$	PURPOSE OF EXPENSE
		\$	
		\$	
		\$	

TOTAL REIMBURSEMENT AMOUNT: \$

I hereby certify under penalty and perjury that this is a true and correct claim for necessary expenses incurred by me and that no payment has been received by me on account thereof.

--- WCIF ADMIN USE ONLY ---

Reimbursement being submitted for:

Payment under Loyalty Program

Other

Approved By:

Last / First Name (PRINT)

Date: _____

Claimant Signature

Date