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

WCIF WASHINGTON COUNTIES INSURANCE FUND

Employer Name:

Address:
(location where check will need to be mailed)

Check Payable To:

Claimant Name (last):

Claimant Name (first):

Claimant Phone #:

Period For: Date To Date

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
				.545	$	
				.545	$	
				.545	$	
				.545	$	
				.545	$	
				.545	$	
				.545	$	

MEALS & LODGING

DATE	MEALS / LODGING	PER DIEM	AMOUNT $	PURPOSE OF MEAL / STAY
	Meals: Lodging:	$	$	
	Meals: Lodging:	$	$	
	Meals: Lodging:	$	$	

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.

Claimant Signature

Date

--- WCIF ADMIN USE ONLY ---

Reimbursement being submitted for:

- ☐ Payment under Loyalty Program
- ☐ Other

Approved By:

Last / First Name (PRINT)

Date:

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