		Vendor Number _____

CITY OF KIRKLAND FINANCE DEPARTMENT ACCOUNTING DIVISION

LEOFF I MEMBER CLAIM FOR EXPENSES

Budget Accounts _____		Amount _____

City Purpose for Expenditures: LEOFF I MEDICAL EXPENSES

Claim of: _____

Address: _____

Department: ☐ Police ☐ Fire

Claim will not be allowed unless all information requested on reverse side of this vouchers shown in detail

EXPENSE BREAKDOWN

For Medical Expenses During the Period of _____ to _____

as shown in detail by attached bills, receipts, and insurance statements.

Medical Services AHR0007005	$	Total from Below
Prescriptions AHR0007001	$	Total from Below
Dental AHR0007002	$	Total from Below
Long-term Care AHR0007003	$	Total from Below
Medicare AHR0007004	$	Total from Below
TOTAL EXPENSES	$	
TOTAL DUE EMPLOYEE	$	

Expenses have been reviewed and claim should be made

Disability Board Staff Assistant DATE:

STATE OF WASHINGTON)
) SS.
CITY OF KIRKLAND)

I, the undersigned applicant, do hereby certify under penalty of perjury that the information contained in the foregoing claim for reimbursement of expenses is true and correct; that the expenses were actually incurred by me as a LEOFF I employee and in a manner consistent with the policies established by Resolution R-3344 relating to reimbursement of employee expenses; that I have not previously been paid or reimbursed for any of said expense.

Signature of Applicant Date

The attention of the applicant is called to RCW Section 9A.72.030, which provides that any person swearing falsely in an affidavit or certifying under penalty of perjury shall be guilty of perjury in the second degree, a class C felony.

PAID TO	FOR	AMOUNT
	LEOFF I MEDICAL	
	LEOFF I MEDICAL	
	LEOFF I MEDICAL	
	TOTAL	$

CITY OF KIRKLAND FINANCE DEPARTMENT ACCOUNTING DIVISION

LEOFF I MEMBER CLAIM FOR EXPENSES

GLASSES 1st PAIR	PAID	ALLOWED		GLASSES 2nd PAIR	PAID	ALLOWED
Frames	$			Frames	$	
Lenses ☐ single ☐ bi ☐ tri	$			Lenses ☐ single ☐ bi ☐ tri	$	
Hardcote	$			Hardcote	$	
Contacts	$			Contacts	$	

DON'T FORGET TO ATTACH THE FOLLOWING:

☐ **Copy of receipt from doctor showing payment or copy of check reflecting payment to doctor**

☐ **Copy of insurance paperwork showing amount patient owes doctor**

☐ **Copy of bill from doctor**

☐ **For Medicare reimbursements, copy of monthly withdrawal statement or year-end statement is all that is needed**

If you have questions, please call Xin (Shinna)
at 425.587.3241