Please complete this form and mail to the Summit Claims department at PO Box 2928, Lakeland, FL 33806-2928

DISTRICT OF COLUMBIA

TRAVEL EXPENSE REIMBURSEMENT FORM

Employee	Claim number	Injury/Illness date
Employer		

Trip date	Physician/Hospital/Therapist	City	Round-trip mileage
		Total mileage	

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee signature_____ Date _____

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Complete este formulario y envíelo por correo al Departamento de Reclamos de Summit, a la siguiente dirección: PO Box 2928, Lakeland, FL 33806-2928

DISTRICT OF COLUMBIA

FORMULARIO DE REEMBOLSO DE GASTOS DE VIAJE

Empleado	Número de reclamo	Fecha de la lesión/enfermedad
Empleador		

Fecha del viaje	Médico/Hospital/Terapeuta	Ciudad	Millaje del viaje ida y vuelta
		Millaje total	

Nota: Debe adjuntar los recibos originales de todos los gastos enumerados.

Firma del empleado _____ Fecha _____

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