



Name: \_\_\_\_\_

## HECS

Name of Institution: \_\_\_\_\_

Amount: \$ \_\_\_\_\_ p.a.      Amount per payment: \$ \_\_\_\_\_

### SUBSTANTIATION REQUIRED

**(a) *Reimbursement (applicable for ALL payments)***

- A copy of the receipt attached to a "Reimbursement Claim Form" at time of claim
- or** A copy of your Higher Education Contribution Scheme Information Statement evidencing payments made

*Employee's Signature* \_\_\_\_\_

*Date* \_\_\_\_/\_\_\_\_/\_\_\_\_