Risk Symposium Travel Reimbursement

Purpose:
In order to support continuing risk management and patient safety education, thereby reducing negligence claims, BETA Healthcare Group (BETA) will reimburse reasonable travel expenses for attendance at BETA's Risk Management Symposiums.

Scope:
This policy applies to BETA members and insureds, which includes BETA Risk Management Authority and Health Providers Insurance Reciprocal, a Risk Retention Group.

Guidelines:

1. **Travel**
   BETA will sponsor/reimburse travel for up to twelve seats (includes a maximum of four patient centered care/senior leadership seats, four ED seats and four Perinatal seats) per hospital/medical group as follows:

   a. **Mileage** at the IRS approved, round-trip rate (minus regular work commute miles), and/or
   b. **Round-trip coach fare** airline ticket up to a maximum of $300.
   c. **On-site self-parking** fees.
   d. **Hotel accommodations** at the designated hotel, for one night (at the negotiated and single occupancy rate), if the commute to the symposium location is 40 miles or further from your home or closest airport.
   e. **Meals** up to $60 per day; all itemized receipts must be provided.

   NOTE: Expenses that will not be reimbursed include: meals during the symposium as meals are provided by BETA, gratuities greater than 20%, laundry, telephone, internet, in-room movie, health club and spousal/companion expenses.

2. **Required Documents**
   Itemized receipts are required for all expenses submitted for reimbursement, including the detailed hotel bill, and must accompany the completed reimbursement form.

3. **Reimbursement Checks**
   Reimbursement checks will be issued within ten business days following the receipt of your request.

4. **Deadline for Submission**
   Requests for reimbursement must be submitted within three months following the symposium.

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For reimbursement, please fill out the form below and send to:

Risk Management - Admin

BETA Healthcare Group
1443 Danville Boulevard
Alamo, CA 94507
925.838.6070 **MAIN** | 818.547.3888 **FAX**

ATTENDEE NAME

HOSPITAL/FACILITY/MEDICAL GROUP

SYMPOSIUM INFORMATION

TITLE

DATE LOCATION

EXPENSES

Hotel $ _____

Meals $ _____

Air Travel $ _____

Taxi / Shuttle / Parking $ _____

Total miles driven ____(-) less work commute _____ = Qualified mileage _____ x $0.565 per mile $ _____

Total $ _____

Please attach all itemized receipts for expenses submitted.

Make check payable to:

NAME

MAILING ADDRESS PHONE NUMBER/EMAIL ADDRESS