Adoption Assistance Claim Form

Associate Information:

Name: _____ Location: _____

Associate ID (CHRIS / Oracle / Gilt): _____
Address: _____
City: _____ State: _____ Zip Code: _____ Work Phone Number: _____ Home Phone Number: _____

New Family Member(s):

Name of First Adopted Child: _____
Date of Birth:_____ Date of Adoption*: _____
Name of Second Adopted Child: _____
Date of Birth: _____ Date of Adoption*: _____

*NOTE: If you are eligible for HBC medical coverage, you may elect health plan coverage for yourself, your family and your adopted child(ren) within 31 days of the date of adoption.

Eligible Adoption Expenses:

Date Paid Amount Description

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Total _____

NOTE: Please attach receipts in US dollars for all expenses listed above, as well as a copy of the adoption placement decree.

Associate Request for Reimbursement:

I certify that this is a claim for allowable expenses under the HBC Adoption Assistance Plan. (Mail claim form and itemized receipts to: HBC Benefits Dept., 250 Highland Park Blvd. Wilkes-Barre, PA 18702; Attn: Ruth Noss)

_____ _____
(Associate Signature) (Date)

Benefits Use Only

Manager Signature: _____ Date: _____