Hope College

Adoption Benefit Payment Request

Employee Name: ________________________________________________________________

Child’s Name (if known): _______________________________________________________

Effective Date of Adoption (if known): ___________________________________________

Adoption Agency Name: _______________________________________________________

Do you have current Health Insurance Coverage with Hope College?   ____Yes   ____No

Eligible Costs Being Submitted for Reimbursement (attach bills or receipts):
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Date of Request: ______________________

Signature of Employee: _______________________________________________________

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Human Resources Approval of Payment
(to be completed by HR)

Date: _____/_____/_____ Eligible Adoption Amount Per Policy: $_____________

Expenses Reimbursed To Date: $____________

Amount Approved This Reimbursement: $____________

New TOTAL Expenses Reimbursed To Date: $____________

Reimbursed as 630 on Pay Date: _____/_____/_____ HR Initials: _________________