ADOPTION ASSISTANCE PLAN
EXPENSE REIMBURSEMENT FORM

EMPLOYEE INFORMATION

Name:
SSN

CHILD INFORMATION

Name:
Date of Birth:
SSN / Adoption Taxpayer Identification Number:

ADOPTION AGENCY INFORMATION
(attach a copy of the placement agreement or order, adoption certificate, surrender papers, or other documents evidencing the adoption)

Name:
Address:
City, State, Zip code:
Tax Identification Number:

EXPENSE INFORMATION
(attach originals of all itemized receipts)

☐ **Court Costs:**	$
☐ **Attorney Fees:**	$
☐ **Adoption Agency Fees:**	$
☐ **Charges for immigration services, including immunizations and translation fees:**	$
☐ **Other:**	$
☐ **Other:**	$
☐ **Other:**	$
☐ **Other:**	$
Total Requested Reimbursement:	$

(NOTE: $5,000 maximum per adoption; $10,000 life time benefit)

EMPLOYEE CERTIFICATION

I hereby certify that I have read a description of Stryker's Adoption Assistance Plan and agree to and understand its terms. I understand that payments to me under the Plan are treated as a taxable fringe benefit, subject to all payroll taxes (FICA, FUTA, federal and state income taxes).

Employee Signature ______________________ Date ______________________

For Plan Administrator Use Only

EMPLOYEE INFORMATION

Date of Hire: Coverage Effective Date:

CLAIM REVIEW CHECKLIST

- ☐ Dates of services were incurred after the Plans effective date
- ☐ Dates of services were incurred after the employee's coverage effective date
- ☐ Adopted child must be under age 18 or unable to care for himself/herself due to a physical or mental disability

Total amount previously paid under the plan:	$
Approved reimbursement amount:	$
Cumulative reimbursements under the Plan ($10,000 maximum lifetime benefit):	$

Approved by ______________________ Date ______________________