

ADOPTION, SURROGACY & FERTILITY ASSISTANCE FORM

Email claim form and itemized receipts to: shared_services_benefits_operations@hbc.com

Associate Information

Full Name: _____

LOCATION:		
New Family Member(s	5)	
Full Name:		
Full Name:		
Date of Birth:		
Adoption Date:		
Note: If you are eligible for medica child(ren) within 31 days of the da		coverage for yourself, your family and your adopted
Data naid	August	Dosavintion
Date paid	Amount	Description



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I certify that this is a claim for allowable expenses under the HBC Adoption, Surrogacy & Fertility Assistance Plan. I understand that qualification to receive reimbursement is based on my eligibility as a full-time associate or as a part-time associate working 20 or more hours per week with at least 1 year of service. In addition, I acknowledge that the receipts submitted will be reviewed for reimbursement up to \$5,000.

Associate Signature		Date
нвс	Benefits Team Use Only	
НВС	Benefits Team Use Only	