



ADOPTION, SURROGACY, & FERTILITY ASSISTANCE FORM

Email claim form and itemized receipts to:

shared_services_benefits_operations@hbc.com

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

HBC Benefits Team Use Only

Manager Signature _____ **Date** _____