ADOPTION, SURROGACY & FERTILITY ASSISTANCE FORM

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

Associate Information

Full Name: _____
Location / Store #:_____
Associate ID: _____
Address: _____
Contact #: _____
Email address: _____

New Family Member(s)

Full Name: _____
Date of Birth:_____
Adoption Date: _____

Full Name: _____
Date of Birth: _____
Adoption Date: _____

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

Eligible Expenses

Date paid	Amount	Description

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I certify that this is a claim for allowable expenses under the SFA Adoption and Surrogacy 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 and my employment is in good standing. In addition, I acknowledge that the receipts submitted will be reviewed for reimbursement up to $5,000.

Associate Signature **Date**

SFA Benefits Team Use Only

Manager Signature_____ **Date**_____

Revised 4/28/2022

Questions?
SFA_Benefits@hbc.com