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: _____