WellSpan Health Adoption Assistance Program Policy
Adoption Assistance Request Form

Name:_____ Member ID:_____
Address:_____
Telephone:_____
E-mail Address:_____

Complete the information below for qualified adoption expenses paid or incurred by you. (For information as to what expenses can and cannot be reimbursed, see the Adoption Assistance Program Description and Employee Notification.) Along with this Form (properly completed and signed) you will also need to submit:

- documentation (bills, invoices, statements from independent third parties, receipts, etc.) showing your reimbursable expenses;
- a copy of the final decree of adoption; and
- any additional documentation that the Employer may request.

Be sure to provide all information requested by this Form and attach all required items. If the Form is incomplete, or if required items are not submitted, you will not have completed the steps necessary to file a claim for benefits under the Program. Remember, you must complete all steps required to file a claim within 12 months after the adoption is finalized. Please date and sign the Form, then send it along with your supporting documentation to WellSpan Population Health Attention: Claims, 3421 Concord Road, York, PA 17402 or via email to **pophealthbenefits@wellspan.org**.

Expenses for Which Adoption Assistance Reimbursement Are Requested

Date (Paid or Incurred)	To Whom Paid or Incurred	Description	Amount
			$
			$
Total Reimbursement:			$

I do/do not have access to adoption assistance from a source other than the Employer (e.g., a governmental agency or a plan covering my spouse).

I certify that I have received and read a copy of the WellSpan Health Adoption Assistance Program Policy Description and Employee Notification and that the expenses for which I am seeking reimbursement are qualified adoption expenses the Program.

I also understand that the Employer does not make any commitment or guarantee that amounts paid to me under this Program will be excludable from my income for federal, state or local tax purposes, or that any other federal, state, or local tax treatment will apply to or be available to me. I understand that it is my obligation to determine whether any payment made under this Program is excludable from my income for federal, state, or local tax purposes.

I further acknowledge that to the extent any income tax exclusion or credit may be available to me, I cannot claim both the exclusion and the credit for the same expense.
Signature

I certify that the information provided on this form is correct and complete.

Signature _____
Date _____