EAB GLOBAL, INC.
ADOPTION ASSISTANCE
REIMBURSEMENT REQUEST FORM

Employee Name Date

Job Title

Home Address

Preferred Contact (please circle whether home or work)
Home/Work Phone: Home/Work E-Mail:

Name of Spouse or Partner:
Is this person currently an employee with EAB? Yes No

Child(ren) Name(s)	Original Country of birth or residence	Birth Date

Have you or any member of your household previously utilized the EAB Adoption Assistance benefit? Yes No

If yes, please complete the following:

Year(s) of use: _____

Name of employee who received the assistance: _____

(Note: the benefit is restricted to two adoption events per household.)

Does this adoption involve more than one child from the same family (i.e., siblings)? Yes No

If yes, please explain:

(Note: For siblings adopted simultaneously, this reimbursement will only count as one adoption event towards the plan's lifetime maximum. The total reimbursement amount will not be multiplied by the number of siblings being adopted.)

For adoption of an eligible child who is a U.S. citizen or resident, date adoption was finalized: _____

OR date adoption proceedings were terminated: _____

For a foreign adoption, the date the adoption was finalized: _____

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Please submit the following documentation

For adoption of a child who is not a citizen or resident of the U.S.: final decree of adoption by a competent authority of the foreign-sending country establishing a parent-child relationship under the laws of the foreign-sending country as well as evidence that the child has been issued the appropriate visa from the State Department of the United States.

For adoption of a child who is a citizen or resident of the U.S.: provide a final decree of adoption or documentation of the termination of the adoption proceedings.

EXPENSES SUBMITTED FOR REIMBURSEMENT *

Type of Service (please √)	**Service Provider**	**Date(s) of Services**	**Amount**
□ Legal Costs □ Attorney's Fees □ Adoption Fees □ Travel Costs □ Medical Costs □ Other (Please explain:)			
□ Legal Costs □ Attorney's Fees □ Adoption Fees □ Travel Costs □ Medical Costs □ Other (Please explain:)			
□ Legal Costs □ Attorney's Fees □ Adoption Fees □ Travel Costs □ Medical Costs □ Other (Please explain:)			
		TOTAL	

*** All expenses must be submitted within 6 months of the date the adoption was finalized (or the date terminated, in the case of a domestic adoption that is terminated) and must be documented through detailed receipts, invoices, canceled checks, etc. attached to this form.**

EMPLOYEE STATEMENT OF UNDERSTANDING

I certify that I am eligible to participate in the EAB Global, Inc Adoption Assistance Plan. That is, I am an active full-time employee who is eligible for employee benefits.

I certify that the receipts or canceled checks I am submitting are for qualified adoption expenses under the Adoption Assistance Reimbursement Program. Qualified adoption expenses mean reasonable and necessary adoption fees, court costs, attorney's fees, and other expenses directly related to, and whose principal purpose is for, the legal adoption of an eligible child under 18 years of age.

I certify that these expenses are not incurred in violation of state or federal law or in carrying out any surrogate parenting agreement, nor are these expenses incurred in connection with my adoption of the child of my spouse or domestic partner. Furthermore, these expenses have not been nor, will they be reimbursed under any plan other than this Adoption Assistance Plan or from any other source.

I certify that these expenses are within the limits of up to two adoptions per household for the lifetime of employment with EAB. I understand that if siblings are adopted simultaneously, this counts as one adoption for the household and that up to $5,000 of qualifying reimbursements is allowed inclusive of all children adopted at that time.

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

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

_____ _____

(Signature of Applicant) (Date)

PLEASE COMPLETE BOTH SIDES AND SUBMIT FORM TO

Email address: Benefits@eab.com