Adoption & Surrogacy Reimbursement Application Form

Arkema members who satisfy the eligibility criteria are eligible for reimbursement up to $25,000 lifetime maximum (combined with the fertility benefit) for covered expenses incurred by the member through a legal adoption or surrogacy agreement, upon being granted legal custody of the child(ren). The member who is the intended parent may apply for reimbursement as soon as the adoption or surrogacy agreement has been legally finalized but no later than 180 days after the birth or custody of the child(ren) or conclusion of the agreement occurs.

Submit completed and signed form along with the required documentation and itemized bills to WIN via email at: WINSpecialtyServices@WIN-Healthcare.com

Date of Application: _____ Employee ID:_____

APPLICANT INFORMATION----------

First Name: _____Middle Initial: _____Last: _____

Home Address: _____

Apt. #: _____City, State, Zip:_____

Home Phone/Cell: _____ Work Phone: _____

Date of Birth:_____ Date of Hire:_____ Employee Email:_____

CHILD(REN) INFORMATION----------

Child First Name: _____Middle:_____Last:_____

Date of Birth (mm/dd/yyyy):_____

Date Adoption/Surrogacy was Finalized: _____Date of Placement:_____

Child First Name: _____Middle:_____Last:_____

Date of Birth (mm/dd/yyyy):_____

Date Adoption/Surrogacy was Finalized: _____Date of Placement:_____

ADOPTION / SURROGACY AGENCY INFORMATION----------

Name:_____Tel:_____

Address: _____

City, State, Zip:_____

ELIGIBLE REIMBURSABLE ADOPTION/SURROGACY EXPENSES----------

Please attach verifying documents that demonstrates a legal adoption or surrogacy arrangement has been executed and is legally finalized, itemized receipts and proof of payment. For a list of required documents and eligible expenses please contact WIN at 844-943-6166 for a copy of the Adoption & Surrogacy Reimbursement Program Policy. (Please list additional expense in a similar format as below).

Date Incurred ***(mm/dd/yyyy)***	Description of Expenses:	Amount
		$
		$
		$
		$
		$
	Total Requested Reimbursement	$

STATEMENT OF UNDERSTANDING ----------

I certify the above is true and correct. I understand the tax implication as outlined in Arkema's Surrogacy and Adoption Reimbursement Policy and realize it is my responsibility to file the appropriate taxes on my personal tax return and these expenses have not been previously claimed by me for purposes of receiving a tax credit.

I certify that the receipts and proof of payment that I am submitting are qualified adoption or surrogacy expenses under the Arkema's Adoption & Surrogacy Reimbursement Program.

I certify that these expenses are not incurred in violation of state or federal law or in carrying out any adoption or surrogate parenting agreement. Furthermore, these expenses have not been nor will they be reimbursed under any plan other than this Adoption & Surrogacy Reimbursement Program or from any other source.

Applicant Signature: _____ Date:_____

Printed Name: _____

Please return approved form to: WINSpecialtyServices@WIN-Healthcare.com

----------The following will be completed by WIN upon receipt of application----------

WIN VALIDATION & AUTHORIZATION FOR REIMBURSEMENT---------- Authorized

Agent Signature:_____ Date:_____

Printed Name: _____ Approved Amount: _____