MEDICA®

Adoption Assistance Program Request for Reimbursement

Instructions:
- Complete all requested information on this form.
- Attached documentation of expenses to be reimbursed. Documentation may include: copies of bills, receipts for expenses, a signed letter from an agency, or a letter from the court or government agency specifying the nature of the adoption expense.
- Send this form with the documentation to the address listed below.
- Reimbursement will be made to you on your payroll check.

EMPLOYEE - PLEASE COMPLETE SECTIONS 1-2. PLEASE PRINT.

1. EMPLOYEE INFORMATION

Full Name (First MI Last)	Social Security Number	Employee Number
Address (Street Box)	Day Phone Number	Today's Date
City State Zip	Department Name	Internal Mail Route

2. EXPENSE DESCRIPTION

Date Expense was incurred	Amount to be reimbursed	Brief description of Expense
Total:		

Is your spouse or same-sex domestic partner also an employee of Medica Health Plan? (Please check a box) ☐ Yes ☐ No

I request payment of $ _____ for the above adoption expenses. To the best of my knowledge, these expenses are eligible under the plan. I certify that these expenses have not been and will not be reimbursed form another source.

Employee Signature Date

For HR use only

Meets employment eligibility ☐

Meets expense eligibility ☐

Funds available for reimbursement ☐

HR Business Partner: _____

Processed by: _____ Date: _____

If you have any questions on how to complete this form contact your HR Business Partner, *Please return form to:*
Medical Human Resources Business Partner - Mail Route 80175