

Flexible Spending Account (FSA) Reimbursement

ADOPTION ASSISTANCE EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Amount to be Reimbursed
Notice: Receipts Required – Minimum claim requirement \$25.00			Total:

*NOTE: The total amount claimed under the Plan for a coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse (If your spouse is either a full time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, and \$400 if there are two (2) or more). No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned and unless an expense for which payment of reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plans which relate to such expenses.

Employee Signature

Date