

Adoption & Surrogacy Reimbursement Application Form

ZOLL Medical employees who satisfy the eligibility criteria are eligible for reimbursement up to \$15,000 lifetime maximum for covered expenses incurred by the employee through a legal adoption or surrogacy agreement, upon being granted legal custody of the child(ren). The employee 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 WINFertility 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: _____

Employee Date of Birth: _____ Date of Hire: _____

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 WINFertility at 844-420-6673 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 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 ZOLL Medical 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: _____

WINFERTILITY VALIDATION & AUTHORIZATION FOR REIMBURSEMENT-----

Authorized Agent Signature: _____ Date: _____

Printed Name: _____

Validated Reimbursable Expenses Total: \$ _____