Flexible Spending Account
ADOPTION ASSISTANCE PLAN
Claim Form

Mail (or) Fax to:
PayFlex Systems USA, Inc.
P. O. Box 3039
Omaha, NE 68103-0039
Fax: (402) 231-4310

This form is to be used to reimburse employees for eligible qualifying expenses associated with legal adoption.

I. Employee Information

Name: _____ **SSN**: _____ - _____ - _____
(Last) (First) (MI)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer Name: _____

II. Adoption Information

Domestic Adoption: ☐ (USA)

Foreign Adoption: ☐ (Overseas) Country of Adoption: _____

Adoptive Child's Name: _____
(Last) (First) (MI)

The date the adopted child was placed in my home was: _____
(month/day/year)

The expected legal final adoption date will be: _____
(month/day/year)

Date	Explanation of Expense (Reasonable & customary public & private agency fees, legal & court fees, medical & hospital fees, transportation fees associated with adoption, temporary foster care charges, etc.)	Amount Requested

Total Reimbursement Request: _____

Please enclose the following:

- Fee Payment Schedule and/or Invoice
- Cancelled Check (s)
- Court Documents

I certify that these eligible expenses have been incurred by me, my spouse or eligible dependent. I understand that "incurred" means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

_____ _____
(Employee/Adoptive Parent Signature) (Date)

******Make copies for yourself, since these documents will not be returned. If you fax your claim, keep the original. ******

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