



Driving the Connection Between Benefit Knowledge and Benefit Power

Adoption Reimbursement Program Form

Name: _____ Work Location: _____ Day Time Phone: _____

Address _____ City: _____ State: _____ Zip: _____

Self-Service ID: _____ Social Security Number _____ Hire Date: _____

I am requesting an Adoption Expense Reimbursement in the amount of \$ _____ (maximum of \$5,000). I have attached all documentation/receipts corresponding to the items below and certify that the attached documentation/receipts are correct and that these expenses were considered eligible based on the guidelines outlined in the current Benefits Guide. I understand that in order to be eligible for a reimbursement, I must be a regular full- or part-time employee and must have completed at least six months and 1000 hours of employment with Caremark. I understand that expenses incurred prior to the completion of this eligibility period will not be considered reimbursable.

I understand the following expenses are considered taxable under current Internal Revenue Service (IRS) regulations:

- Public and Private Agency Fees** Amount: _____
 - Court Costs and Legal Fees** Amount: _____
 - Temporary Foster Care** Amount: _____
 - Foreign Adoption Fees** Amount: _____
 - Pre-Adoption Medical Examination**
(Any treatment, including dental, eyeglass, etc.) Amount: _____
 - Maternity Fees** (Medical expenses for the child's natural mother) Amount: _____
 - Any Other Reasonable and Customary Expense** Amount: _____
- TOTAL:** _____

Employee Signature

Date

Benefits Approval Signature

Scheduled Date of Reimbursement

Please send original completed form and documentation to:

Caremark Benefits Center
 Attn: ADRP Administrator NBT-9
 2211 Sanders Road
 Northbrook, IL 60062