

Hope College

Adoption Benefit Payment Request

Employee Name: _____

Child's Name (if known): _____

Effective Date of Adoption (if known): _____

Adoption Agency Name: _____

Do you have current Health Insurance Coverage with Hope College? Yes No

Eligible Costs Being Submitted for Reimbursement (attach bills or receipts):

Date of Request: _____

Signature of Employee: _____

Human Resources Approval of Payment