



Adoption Reimbursement Plan Application

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| Employee Name | Social Security Number | Department |
| First Name (of adoptee) | Last Name (of adoptee) | Date of Birth |
| Date of Placement in Employee's Home | | Date of Final Adoption |

Eligible Adoption Expenses:

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|--|----------|
| Adoption Agency Fees | \$ _____ |
| Placement Fees | \$ _____ |
| Legal Fees and Court Cases | \$ _____ |
| Medical Maternity Expenses (for adoptee and birth mother) | \$ _____ |
| Travel Expenses (if necessary to pick up child from another location) | \$ _____ |
| Translation & Immigration Assistance and/or fees | \$ _____ |
| Total | \$ _____ |
| Reimbursement Amount (Lesser of Total line or \$5,000) | \$ _____ |

You must attach a copy of documentation stating when the child was placed in your home for adoption, and copies of receipts stating covered expenses paid and dates of payment.

Expenses not covered under this plan include, but are not limited to: voluntary donations or contributions, expenses for the biological parents (e.g. living, counseling or medical – other than maternity), costs to obtain guardianship or custody of a child not associated with the legal adoption of the child, temporary child or foster care prior to placement and any payment prohibited by the state in which the adoption is finalized.

- I certify that the above statements are true, and that I have paid the attached bills associated with the adoption of my child.
- I authorize Valassis Communications, Inc. and its representatives to verify this claim for reimbursement.
- Employee must be an employee in good standing when adoption expenses are incurred and the adoption reimbursement check is cut.
- I agree to provide proof of final adoption, if requested.
- If I am reimbursed through another source for adoption expenses, as well as through Valassis, I agree to reimburse Valassis for any duplication of payment made to me.
- I certify, if the above expenses do not total \$5,000, I do not have any additional expense to submit.
- I understand any reimbursement under this plan will be reported on my W-2 Wage and Tax Statements, under miscellaneous.
- Reimbursement will be issued within 45 days of receiving all required documentation.
- **I understand that I must be actively employed to receive reimbursement. Associates on leave of absence will be reimbursed once they have returned to work. I understand voluntary resignation within 12 months of reimbursement will require me to repay the full amount of reimbursement. I authorize payroll deduction from my last check for this repayment (where allowed by state law).**

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| Employee Signature | Date |
| Human Resources Authorization | Date |