

# Adoption Assistance Plan Claim Form

## Team Member Information:

Name:	_____	Location:	_____
Employee ID Number (7 digits):	_____		
Payroll ID:	_____	Pay Group:	_____
Address:	_____		
City:	_____	State:	_____
	_____	Zip Code:	_____
Work Phone Number:	_____	Home Phone Number:	_____

## New Family Member(s):

Name of First Adopted Child:	_____		
Date of Birth:	_____	Date of Adoption*:	_____
Name of Second Adopted Child:	_____		
Date of Birth:	_____	Date of Adoption*:	_____

\*NOTE: If you are eligible for "R"Benefits, you may elect health plan coverage for yourself, your family and your adopted child(ren) within 30 days of the date of adoption.

## Eligible Adoption Expenses:

Date Paid	Amount	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total	_____	

NOTE: Please attach receipts in US dollars for all expenses listed above, as well as a copy of the adoption placement decree.

## Team Member Request for Reimbursement:

I certify that this is a claim for allowable expenses under the Toys"R"Us Adoption Assistance Plan.

\_\_\_\_\_  
(Team Member Signature)

\_\_\_\_\_  
(Date)

(Mail claim form and itemized receipts to: Toys "R" Us Benefits Dept., One Geoffrey Way, Wayne, NJ 07470)