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)

Benefits Use Only

Manager Signature: _____ Date: _____