Allegiance℠
a Cigna Company
P. O. Box 4346, Missoula, MT 59806

# ADOPTION ASSISTANCE REIMBURSEMENT REQUEST

***To send scanned claims go to:*** www.allegianceflexadvantage.com

**FAX: 406-523-3149 or, toll-free 877-424-3539 PHONE: 406-721-2222 or, toll-free 877-424-3570**

**Please print legibly in black or blue ink. Do not include medical expenses on this form.**
**Do not use a highlighter on this form.**

Employer Name: _____ Total # of Pages Submitted: _____

Employee Name: _____ Please call to confirm receipt? Yes ☐

Employee ID: _____
(Social Security Number or, if assigned, alternate ID) Return Phone Number: _____-_____-____

Comments: _____ Attention: _____

***Qualifying adoption expenses*** are reasonable and necessary adoption fees, court costs, attorneys fees, traveling expenses (including amounts spent for meals and lodging) while away from home, and other expenses directly related to, and whose principal purpose is for, the legal adoption of an eligible child. Expenses are eligible regardless of the outcome of the adoption. Please Include independent, third-party documentation of your expenses with this claim form, invoice or billing or complete receipts.

| TYPE OF EXPENSE | SERVICE DATES | REQUESTED |
|---|---|---|
| _____ | From _____To _____ | $_____.____ |
| _____ | From _____To _____ | $_____.____ |
| _____ | From _____To _____ | $_____.____ |
| _____ | From _____To _____ | $_____.____ |
| | **TOTAL REIMBURSEMENT REQUESTED** | $_____.____ |

Qualifying adoption expenses ***do not*** include expenses:

- You incur while not under this Plan,
- That violate state or federal law,
- For carrying out any surrogate parenting arrangement,
- For the adoption of your spouse's child,
- Paid using funds received from any federal, state or local program, or
- Allowed as a credit or deduction under any other federal income tax rule

I certify that the services described on this claim form were necessary for a legal adoption and that the dates and fees are true and that I have not sought reimbursement elsewhere for these expenses.

Signature (required): _____ Date: _____

☐ Check here if your address has changed. New address: _____

_____