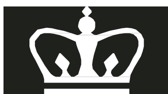

Surrogacy Assistance Program Expense Reimbursement Application

Instructions

Before completing this form, please read about Columbia University's Surrogacy Assistance Program online at http://hr.columbia.edu/find-out-about/benefits/surrogacy. Please contact the Columbia Benefits Service Center at 212-851-7000 if you have questions about the Surrogacy Assistance Program.

When you have completed, printed and signed the form, send to the Benefits Service Center via email at hrbenefits@columbia.edu along with the required original documentation and itemized bills.

Employee Information

EMPLOYEE ID or UNI:_______________ Last Name:____________________________ First Name: ___________________________

Home Address:____ Apt. #: ____________________

City, State, ZIP:____ Home Phone: (   )   - ________

Columbia Email Address:____ Work Phone: (   )   – ________

Child Information

Child's Name: ____

Child's Date of Birth *(mm/dd/yyyy):* * ____________________

Request for Reimbursement

I am applying for reimbursement of the following surrogacy expenses:

Date of Expense *(mm/dd/yyyy)*	**Description** (Include name of person, organization, or entity to which expense was paid. Attach original itemized bills and receipts or cancelled checks, along with paperwork that demonstrates a legal surrogacy arrangement has been executed.)	Amount
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
	Total Requested Reimbursement:	$

* To be eligible for reimbursement, you must submit this application within six months of the date the child was born.

Employee Statement of Understanding

I certify that the receipts or cancelled checks I am submitting are qualified surrogacy expenses under Columbia University's Surrogacy Assistance Program. Qualified surrogacy expenses include pre-treatment evaluation, artificial insemination, donor sperm, donated eggs previously frozen and sold by egg banks, fresh eggs from either a known donor, anonymous donor, or someone already undergoing an IVF cycle, preparation of the uterus, IVF cycle, frozen embryo transfer cycle, embryo transfer, post-transfer monitoring, and expenses related to extraction and/or implantation of eggs or embryos and fertilization of eggs.

I certify that these expenses do not include fees paid to the surrogate or an egg donor/agency, long term (more than 30 days) storage of blood, umbilical cord or other material, costs paid using funds received from any federal, state or local program. Furthermore, these expenses do not violate state or federal law, are not allowed as a credit or deduction under any other federal income tax rule, and have not been nor will they be reimbursed under an employer plan other than Columbia's Surrogacy Assistance Program, nor have they been previously reimbursed by Columbia University's Surrogacy Assistance Program, nor by any other source.

I further acknowledge that to the extent that any income tax exclusion or credit may be available to me, I cannot claim the exclusion and the credit for the same expense.

I understand that Columbia University's Surrogacy Assistance Program is subject to applicable federal, state and/or city taxes, as well as FICA and Medicare taxes.

Employee Signature: ____ Date (*mm/dd/yyyy*):__________________________

Reviewed and approved by:

Signature: Benefits Service Center Specialist____ Date (*mm/dd/yyyy*):__________________________

Name: Benefits Service Center Specialist (*please print*)____

Signature: Director, Benefits ____ Date (*mm/dd/yyyy*):__________________________

Name: Director, Benefits (*please print*)____