

# HONORHEALTH

## APPLICATION FOR ADOPTION BENEFIT

Staff Member Name: \_\_\_\_\_ Emp ID#: \_\_\_\_\_

Department: \_\_\_\_\_ Extension: \_\_\_\_\_

I understand that HonorHealth offers an adoption benefit of **up to \$3,000** for qualified adoption expenses per calendar year, and I hereby apply for this benefit. I understand that this benefit is subject to FICA and FUTA taxes and Federal and State taxes may apply based on the type of adoption.

Date of adoption: \_\_\_\_\_ (attach copies of adoption papers)

Total amount of expenses: \_\_\_\_\_ (attach proof of expenses including name of agent assisting with the adoption, name and date of birth of child)

Type of adoption:

1. \_\_\_\_\_ Adoption through a licensed agency or a private adoption (benefit is non-taxable for Federal and State taxes)
2. \_\_\_\_\_ Adoption of a spouse's child (benefit is taxable)

I understand that this benefit will be included in my paycheck as soon as is practical after all required paperwork is received by Employee Benefits and this application is approved.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Return to:**  
HonorHealth Employee Benefits  
8125 N Hayden Rd  
Scottsdale, AZ 85258

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### For office use only:

Amount of benefit approved: \_\_\_\_\_ ☐ ABFM (1) or ☐ ABAT (2)

Date sent to payroll: \_\_\_\_\_

Charge Dept. 20-9050-63015

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_