

# Ryman Hospitality Properties Adoption or Surrogacy Assistance Reimbursement Form



## Section I: Employee Information

Employee name: \_\_\_\_\_ Department: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

## Section II: Child Information

Child's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Date of adoption\* (if applicable): \_\_\_\_\_

*\*Please attach a copy of the adoption placement certificate or final adoption decree.*

## Section III: Qualified Expenses \*\*

All expenses must be submitted within six months of the date the adoption was finalized.

Date of expense	Description of eligible expense (Attach copies of itemized bills or documents)	Amount of expense

**Total reimbursement amount requested:** \$ \_\_\_\_\_

*\*\* A non-exhaustive list of Qualified Expenses can be found in the Ryman Hospitality Properties Adoption and Surrogacy Assistance Policy (the "Policy").*

## Section IV: Employee Certification

I certify that the expenses included in this request are Qualified Expenses under the Policy. I also certify that these expenses have not been and will not be reimbursed from a source other than the Policy or taken as a tax credit on my income tax return for any year. I understand that it is my responsibility to verify with the Internal Revenue Service (IRS) or my tax consultant the tax implications of receiving this money, and that I assume all tax liability for this reimbursement.

I certify that the information provided on this form is correct and complete.

**Employee signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_