QCR HOLDINGS, INC.

ADOPTION ASSISTANCE REIMBURSEMENT REQUEST FORM

Instructions

Pursuant to the terms and conditions of the QCR Holdings, Inc. Adoption Assistance Plan (the "**Plan**"), you can obtain up to $5,000 in reimbursement of Qualified Adoption Expenses per Eligible Child per adoption (as each term is defined under the Plan), with a lifetime maximum of $10,000. In order to qualify for the reimbursement of a Qualified Adoption Expense under the Plan, you must complete, sign and date, and submit this adoption assistance reimbursement request form (this "**Form**"), with all applicable itemized receipts (written in English and using U.S. dollars), and any other documentation requested by QCR Holdings, Inc., no later than 90 days after a Qualified Adoption Expense is paid or incurred. If this Form is incomplete, or if required items are not timely submitted, you will not have completed a request for the reimbursement of a Qualified Adoption Expense under the Plan.

Please sign and date this Form and provide it along with your supporting documentation to QCRH-benefits@qcrh.com.

Employee Information

Name: _____ Employee ID#: _____

Address: _____ Hire Date: _____

Personal Email: _____ Cell Phone: _____

Child Information

Name: _____ Date of Birth: _____

Qualified Adoption Expenses for which Reimbursement is Requested

Date of Expense MM/DD/YYYY	**Paid To** (Name of Person or Organization)	**Services Rendered** (Legal, Medical, Travel, Lodging, Other)	**Amount**
			$
			$
			$
			$
		Total Reimbursement:	**$**

Certification and Acknowledgements

I certify that I have received and read a copy of the Plan and that the expenses for which I am seeking reimbursement for are Qualified Adoption Expenses under the Plan.

I acknowledge and understand that QCR Holdings, Inc. does not make any commitment or guarantee that amounts reimbursed to me under the Plan will be excludable from my income, or receive favorable treatment, for federal, state or local tax purposes. I understand that it is my obligation to determine the federal, state, and local tax consequences of any payment made under the Plan.

[Signature Page Follows]

Signature

By signing this Form, I affirm that the information provided on this Form is correct and complete.

Signature: _____ Date: _____