JOHNS HOPKINS
UNIVERSITY

GESTATIONAL SURROGACY PROGRAM
EXPENSES REIMBURSEMENT REQUEST FORM

Name of Faculty or Staff (Please Print) **JHED ID**

_____ _____

Address

_____
Street State Zip Code

_____ was born on _____.
(Child's Name) (Month/Day/Year).

Eligible Expenses - Eligible and non-eligible expenses are listed on the JHU Benefits & Worklife website at https://hr.jhu.edu/benefits-worklife/family-programs/new-expecting-parents/

I wish to apply for reimbursement of the following expenses incurred in connection with a gestational surrogacy:

Date	Amount	Explanation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Acceptable documentation of the listed expenses must be attached to this form. All approved expenses reimbursed under the Gestational Surrogacy Program are subject to tax withholding.

Faculty or Staff Signature _____ Date _____

Submit this form and all required documentation to: Johns Hopkins University, Office of Benefits Services, Johns Hopkins at Eastern, 1101 East 33rd Street, Suite C020, Baltimore, Maryland 21218, or fax to 443-997-6812.

Amount Requested for Reimbursement $_____

For Internal Department Use Only:

Amount approved $_____ Approval _____ Date _____

Rev. 01/2023

GESTATIONAL SURROGACY PROGRAM
EXPENSES REIMBURSEMENT REQUEST AFFIDAVIT

I am requesting reimbursement for certain expenses eligible under The Johns Hopkins University Gestational Surrogacy Program in connection with a gestational surrogacy. I understand that The Johns Hopkins University has the right to request sufficient written documentation to establish surrogacy. Accordingly, I hereby certify and affirm the accuracy and completeness of the following facts:

1. I entered into a gestational surrogacy contract in accordance with all applicable law governing said contract;

2. I understand that the University reserves the right to request that I complete additional documents or provide additional substantiation to prove my eligibility for reimbursement of qualifying expenses in connection with a gestational surrogacy and I am willing to provide sufficient written documentation to establish the surrogacy upon reasonable request by the Plan Administrator;

3. I understand that any benefits paid under the Gestational Surrogacy Program are subject to tax withholding;

4. I understand that this information will be held confidential but is subject to disclosure for administrative purposes, as required by law or upon my express written authorization;

5. I understand that any person's eligibility of benefits is subject to auditing by the Johns Hopkins University and its agents for verification purposes; and

6. I understand that if I make a false statement or misrepresentation on this Gestational Surrogacy Program Affidavit, the University reserves the right to take any and all actions necessary to deny benefits or to recover amounts paid for benefits to which a person was not entitled, as well as any expenses or attorney fees incurred by the University in an attempt to recover such amounts and that any false statements on this Affidavit may lead to other disciplinary action, up to and including termination of employment.

Faculty or Staff Signature_____ Date _____

Submit this form to: Johns Hopkins University, Office of Benefits Services, Johns Hopkins at Eastern, 1101 East 33rd Street, Suite C020, Baltimore, Maryland, 21218, or fax to 443-997-6812.

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