SYNOPSYS, INC.
SURROGACY ASSISTANCE REIMBURSEMENT FORM

Instructions: To obtain reimbursement for your eligible surrogacy expenses, please complete and sign this Form. Return the completed Form along with the required documentation (e.g., receipts, etc.) to the Benefits Department. All claims for reimbursement must be submitted no later than 60 days after the end of the Program plan year.

If you have any questions regarding the Synopsys, Inc. Surrogacy Program (the "Program"), you can read about the Program online at benefits.synopsys.com, or contact the Benefits Department at benefits@synopsys.com.

Employee Information

Your name: _____ Social Security Number: _____
Work Location: _____ Work phone #: _____
Home Address: _____

Child's Information

Child's name: _____ Child's date of birth: _____

Request for Reimbursement

Date of Expense (mm/dd/yyyy)	**Description of Eligible Expenses** (Include name of person, organization, or entity to which expense was paid. Attach original itemized bills and receipts)	**Amount**
		$
		$
		$
		$
		$
Total		**$**

Acknowledgements
I certify that the receipts I am submitting are for qualified surrogacy expenses under the Synopsys, Inc. Surrogacy Program. For a complete listing of Qualified Surrogacy Expenses, please consult the Synopys, Inc. Surrogacy Program Document. To obtain a copy of this Program Document, contact Synopsys Benefits at benefits@synospys.com.

I understand that if I am an eligible employee, I may obtain up to $10,000 each year/per surrogacy in qualified surrogacy expenses that are paid or incurred while I am an eligible employee.

I further acknowledge that the benefits paid under the Program are not excludible from income, and reimbursements under this Program are subject to applicable federal and state taxes.

I hereby certify that the information provided on this Form is correct and true to the best of my knowledge. I have read and understood the Synopsys, Inc. Surrogacy Program Document.

_____ _____
Employee Signature Date