



Modern Business Associates

DEPENDENT CARE  
2010 CLAIM FORM

1. Attach all supporting insurance claim worksheets, bills, or receipts. Ensure that the documentation contains the name of the person receiving the service, the service provider's name, date of service, type of service provided, total expense amount, insurance payment (if applicable), and your total out of pocket expense.
2. All documentation should contain the Federal Tax ID of the service provider, or social security number if using a baby-sitter.
3. If your balance is not reimbursed in full due to missing documentation or you have requested more than your balance on the account, you will be required to fill out a new claim form when resubmitting.
4. Make a photocopy for your records.

NAME: \_\_\_\_\_ SS# \_\_\_\_\_  
Last, First, Middle

COMPANY NAME: \_\_\_\_\_ CURRENTLY EMPLOYED WITH THIS COMPANY? \_\_\_\_\_

CLAIMS FOR THE TIME PERIOD: \_\_\_\_\_, 2010

**Certification:** I certify the accuracy of the below information, that these claims are for persons covered under the Dependent Care Expense Reimbursement Plan, and that I am not entitled to reimbursement from any other source.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

	Date Incurred	For the Benefit of - Name & Relationship	Description	Amount	Approved Y/N *MBA Only
1				\$	
2				\$	
3				\$	
4				\$	
5				\$	

TOTAL: \$

**For MBA Use Only**

Total approved amount: \_\_\_\_\_

Reason for decline:

Processed By: \_\_\_\_\_

Date: \_\_\_\_\_

Approved By: \_\_\_\_\_

Date: \_\_\_\_\_

Mail to: MBA 9455 Koger Blvd., Suite 200 St. Petersburg, FL 33702 or Fax to (727)563-1517