121 Benefits
Phone: 800.300.1672 or
612.877.4321
www.121benefits.com

Flexible Benefits Enrollment Form

Benefit Year _____ Social Security Number _____

Last Name _____ First Name _____ Middle Initial ____

Address _____City _____ State ____ Zip Code _____

Employer _____

Date of Birth _____ Date of Hire _____

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

I authorize the following amount to be deducted from my paycheck and placed in my Health Care Flexible Spending Account: ($2700 limit)

$_____/year which is $_____/paycheck

☐ I do not wish to participate in the Health Care Flexible Spending Account.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FOR DAYCARE EXPENSES)

I authorize the following amount to be deducted from my paycheck and placed in my Dependent Care Flexible Spending Account: ($5000 limit)

$_____/year which is $_____/paycheck

☐ I do not wish to participate in the Dependent Care Flexible Spending Account.

I authorize my employer to make the above deductions from my paycheck on a pre-tax basis. I understand that I will be able to request reimbursement for the withheld monies when I incur eligible expenses during the plan year in accordance with the plan documents.

Employee Signature ***Please SIGN and DATE completed form** Date _____

FOR EMPLOYER USE ONLY

Employer Name _____ Payroll Frequency _____

Employer Address _____

Effective Date _____ Signature _____ Date _____

RETURN TO EMPLOYER

PRINT **SAVE**

Rev. 11/2018