

121 Benefits

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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:

\$ _____/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:

\$ _____/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 _____ Date _____

FOR EMPLOYER USE ONLY

Employer Name _____ Payroll Frequency _____

Employer Address _____

Effective Date _____ Signature _____ Date _____