121 BENEFITS™

For fast and easy submission, submit your expenses via our mobile app or log into your account online at www.121benefits.com.

Reimbursement Request Form

Please Complete All Information and Attach Itemized Documentation for Each Expense Listed

Benefit Year: _____

Employer: _____

Social Security Number (last 4 digits): _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: (_____) _____ E-mail: _____

Unreimbursed Medical/Dental/Vision Expense (for you, your spouse and your dependents)

	Date(s) of Service (MM/DD/YY)	Person for Whom Expense was Incurred	Expense Description	Name of Service Provider	Net Amount*
1					
2					
3					
4					
5					
6					
Note: If you need additional space, attach a separate sheet of paper.			**Total Unreimbursed Medical/Dental/Vision Expense Claimed:**		$ 0.00

*Net amount is the amount of the claim not reimbursed to you through another plan; I.e. health or dental insurance.

Unreimbursed Dependent Care Expense (Daycare Expenses)

	Period Covered MM/DD/YY) to (MM/DD/YY)		Name of Dependent	Identify below the Provider Name, Tax ID and Signature OR attach a receipt from the Provider with the Provider Name, Tax ID and Signature. The information is required with each submission.	Actual Amount Incurred
7				Provider Signature:	
8				Provider Signature:	
9				Provider Signature:	
Note: If the same Provider for each claim is listed above, signature is required only once.				**Total Unreimbursed Dependent Care Expense Claimed:**	$ 0.00

Read Carefully

The undersigned participant in the plan certifies that all expenses for which reimbursement of payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the company's cafeteria plan. The undersigned fully understands that he/she alone is responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned and that, unless an expense for which payment of reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related federal, state, or city income tax on amounts paid from the plan which relate to such expense.

***Please SIGN and DATE completed form**

Employee Please Sign Here (signature is required) **Date**

PRINT **SAVE**

Upload on the 121 Benefits Mobile App, Online or Mail to:

730 2nd Avenue South Suite 400 | 730 Building | Minneapolis Minnesota 55402 | T: 800.300.1672