MINNESOTA STATE

MINNESOTA STATE
Reimbursement Request Form
MDEA, HRA AND DCEA

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

Complete the information below for expenses incurred by you, your spouse, or other eligible dependents for which you request payment. See reverse side for complete instructions. If the form is incomplete it will be returned to you and your reimbursement will be delayed. Print or type the information requested, then date and sign the form. Keep a copy of all documentation for your records. There is a $50.00 minimum reimbursement amount except for claims filed after the last week of the plan year. Submit your expenses via our mobile app or log into your account online at www.121benefits.com, or send the original form with documentation to:

Fax 612.877.4322 or 877.918.3622
730 2nd Ave. S., Ste. 400
730 Building
Minneapolis, Minnesota 55402

121 BENEFITS™

Benefit Year: _____2021_____

Employee ID Number: _____

First Name: _____ MI: _____

Last Name: _____

Address: _____

City: _____State: _____ZIP: _____

Daytime Phone: (_____)_____

Email: _____

Unreimbursed MDEA or HRA 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					
				Total Unreimbursed MDEA or HRA Expense Claim:	

Note: If you need additional space, attach a separate sheet of paper.

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

**Claims will be reimbursed from the Medical/Dental Expense Account first; when the MDEA has been exhausted, remaining claims will be reimbursed from the HRA account.

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
6					
				Provider Signature:	
7					
				Provider Signature:	
8					
				Provider Signature:	
				Total Unreimbursed Dependent Care Expense Claim:	

Note: If the same Provider for each claim is listed above, signature is required only once.

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.

_____ _____

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