121 Benefits
730 2nd Ave. S., Ste. 400
730 Building
Minneapolis, MN 55402
Phone: 800.300.1672
www.121benefits.com

Flexible Benefits Enrollment Form

Benefit Year: _____ Employer: _____ Date of Hire: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

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: **$2,750/year employee maximum.**

$ _____/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: **$5,000/year maximum per family.**

$ _____/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: _____

RETURN TO EMPLOYER

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