FBMC
proven benefit solutions
P.O. Box 1878, Tallahassee, FL 32302-1878

The Research Foundation of State University of New York
Plan Year January 1, 2007, through December 31, 2007

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Press hard with ballpoint pen. You must complete this form if you wish to start or continue a tax-free Health Care and/or Dependent Care Spending Account.

Name (Please Print) Last	First	MI	Social Security #

Home Address Street	City	State	ZIP Code

Daytime Phone	Home Phone	Date of Hire	Date of Birth	Work Location
( )	( )			

Enrollment Status: ☐ OPEN ENROLLMENT* ☐ CHANGE IN STATUS ☐ NEW HIRE Effective Date

E-mail Address:

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
Complete the worksheets provided in your Flexible Spending Account (FSA) Reference Guide before deciding on the amount.
If you have questions, consult your FSA Reference Guide, or contact FBMC Customer Service by calling 1-800-342-8017.

In Box #1, indicate the dollar amount you elect to contribute for the upcoming plan year.
In Box #2, indicate the number of regular payroll checks with deductions you expect to receive during the upcoming plan year.
In Box #3, indicate the deduction amount per paycheck. (Note: if Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding).

By signing this form, you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement or any other anticipated leave.

Health Care Flexible Spending Account

For uninsured eligible health care expenses incurred by you, your family members, or both.
(Minimum contribution is $5 per pay period; maximum allowable contribution is $4,000 annually.)

Box #1
Total Plan Year Dollar Amount from your Worksheet _____

Box #2
Number of Regular Paychecks Expected _____

Box #3
Reduction Per Regular Paycheck _____

Dependent Care Flexible Spending Account

TAX FILING STATUS Please check one: (Minimum contribution per pay period is $5.)
- ☐ Married, filing separately [maximum - $2,500]
- ☐ Married, filing jointly [maximum - $5,000]
- ☐ Head of household w/ one dependent [maximum - $3,000]
  w/ two dependents [maximum - $5,000]

Box #1
Total Plan Year Dollar Amount from your Worksheet _____

Box #2
Number of Regular Paychecks Expected _____

Box #3
Reduction Per Regular Paycheck _____

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal and state income and Social Security taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved Change In Status with the contract administrator within **60 days** of the event or before the end of the plan year.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA 3) I will not seek reimbursement through any additional source and 4) I will collect and maintain sufficient documentation to validate the foregoing.

Employee Signature	Date Signed

***Submit your completed Enrollment Form to your benefits office by November 30, 2006.**

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES