

FLEXIBLE BENEFITS PLAN

PARTICIPANT WAIVER FORM

FOR REGULAR EMPLOYEES

I, the undersigned employee of The Research Foundation of State University of New York (the "Foundation"), being a participant in the Foundation's Health Insurance Plan for Regular Employees, do hereby elect <u>not to participate</u> in the Foundation's Flexible Benefits Plan.

I understand that this election will remain in effect for the Plan Year and for each succeeding Plan Year, unless and until such election is revoked by me during a future open enrollment period, or I meet a qualifying event, as permitted under the terms of the Flexible Benefits Plan.

I also understand that by electing not to participate, my salary from the Foundation will <u>not</u> be reduced by the amount of my required payments under the Health Insurance Plan as previously disclosed to me, and I will therefore be subject to State and Federal income and Social Security taxes with respect to these amounts. I also understand that this election, once made, may not be changed or revoked during the Plan Year to which it pertains.

I hereby acknowledge receipt of copies of the Regular Employee Summary of Fringe Benefits and the Research Foundation Benefits Handbook and represent that I have reviewed the same and fully understand and accept the terms and provisions of each Plan prior to making this election.

Date	Employee
	Social Security Number
ACCEPTED BY:	
Research Foundation	

Attachments