



Effective Date of Election:

____ / ____ / ____

**RESEARCH FOUNDATION FOR MENTAL
HYGIENE, INC.***Flexible Benefits Plan*

Salary Reduction and Enrollment Form

 Enrollment Change**Plan Number: 1885****Expense Period From: January 1, 2007 To: December 31, 2007**

Employee Name	Social Security #	E-mail address
Mailing Address	Phone Number: Work:	Home:
	()	()

Flexible Spending Accounts	I elect to participate in the Flexible Benefits plan and receive non-taxable benefits by reducing my compensation by the amounts listed below. Each of my elections satisfy the requirements of the Plan as described in the Flexible Benefits Plan Document.			
	I HEREBY ELECT PER PAY PERIOD:			
		Flexible Spending Account Annual Amount	# of Pay Checks	Per Pay Period Election
	Health Care FSA	\$ _____ ÷ _____ = \$ _____		
	Dependent Care FSA *	\$ _____ ÷ _____ = \$ _____		
TOTAL FSA SALARY REDUCTION EXPENSES	\$ _____ ÷ _____ = \$ _____			
* I understand that I am responsible for obtaining a completed IRS Form W-10 from my dependent care provider and that I must also complete the <i>Dependent Care Certification of Eligibility Form</i> before I may be reimbursed for my dependent care expenses..				

Benny Card	<input type="checkbox"/> Please issue, (or renew) the Benny Card for me to use with my Healthcare Flexible Spending Account.
	<input type="checkbox"/> I elect NOT to receive (or renew) the Benny Card.
I agree to acquire and retain the required substantiation for any expense paid with the Benny card, including invoices and receipts. I am responsible for all charges made with the Benny Card. If the card is lost or stolen I will promptly notify the administrator. If the Plan Administrator determines that I have used the Benny Card for a non-qualified expense, or if I fail to substantiate an expense upon request; I agree to repay, to the Plan, the amount of that expense. The Benny Card may be suspended if I do not comply with the terms of the Plan or the Cardholder Agreement.	

Approval	Forfeiture of Unused Benefits
	If at the end of the election period, the total declared reduction in compensation exceeds my actual expenditures, I understand that the excess will be forfeited.
	Employee Agrees and Understands
	That the Section 125 deductions are pre-tax, and may not be itemized and deducted again, when filing IRS Form 1040; That the election amounts as stated above, may not be changed or revoked during the plan year unless I have a qualifying event, as described in the Summary Plan Description; That if the employer incurs a liability for failure to withhold federal, state, local, or FICA taxes due to a fraudulent act of the employee, the employee will indemnify and reimburse the employer that liability upon demand.
IN WITNESS THEREOF, I certify that the above elections are correct; I have read and understand the reverse side of this document as well as the Summary Plan Description (SPD); and that I agree to comply with the terms and conditions of the Plan.	
_____	_____
Date	Employee Signature
_____	_____
Date	Witness Signature (Human Resources Representative)

Participant Acknowledgment

I hereby elect to use a portion of my annual wages or salary from RESEARCH FOUNDATION FOR MENTAL HYGIENE, INC. to establish a healthcare flexible spending account and/or a dependent care flexible spending account under the plan. I agree to comply with the rules of the plan. I understand that, except in the event of a change in family status, or another event which permits a change under the IRS regulations, this election may not be revoked or changed until January 1st of the following Plan year.

I understand that:

- I may not change my election unless I have a qualifying event as defined by the Plan;
- Amounts reimbursed under the plan for dependent care cannot be used to claim a dependent care income tax credit;
- Any amount set aside for healthcare expenses can only be used for healthcare expenses which are not paid from any other source;
- Any amount set aside for dependent care expenses can only be used for dependent care expenses which are not paid from any other sources;
- Claims for reimbursement of expenses incurred in any year must be submitted by February 28th of the following year;
- Any balance left in my account(s) at the end of this period will be forfeited;
- Amounts paid under this salary reduction agreement reduce my compensation for Social Security tax purposes. This could result in my Social Security benefits being decreased because of the decrease in the amount of compensation which is considered for purposes of Social Security benefits; and
- My compensation will be reduced by the amount of my contribution for the insurance benefit plans or policies I have elected to participate in under the Flexible Benefits Plan. The amount of my required contribution for each insurance benefit plan or policy which I am eligible to select is set forth on a schedule which has been provided to me.
- My expenses may not be itemized and deducted again, when filing IRS Form 1040.
- If RESEARCH FOUNDATION FOR MENTAL HYGIENE, INC. incurs a liability for failure to withhold federal, state, local, or FICA taxes due to my fraudulent action, I will indemnify and reimburse RESEARCH FOUNDATION FOR MENTAL HYGIENE, INC. that liability upon demand.
- If I requested that a stored-value debit card (the Benny Card) be issued to me; I certify that the card will only be used for eligible medical care expenses, as defined in § 213(d), incurred by me, my spouse, or my qualifying dependents. I will only use the Benny Card for expenses that have not been reimbursed and I will not seek reimbursement for those expenses under any other plan covering health benefits.