

UNIVERSITY OF ARKANSAS

Flexible Benefits Plan

(Formerly known as the Cafeteria Plan)

PLAN YEAR: January 1, 200__ through December 31, 200__

A - PARTICIPANT INFORMATION

PARTICIPANT NAME:	SOCIAL SECURITY NUMBER
MAILING ADDRESS (City, State, Zip):	
PAYROLL CYCLES: [] Bi-Weekly(____ Pay Periods) [] Semi-Monthly(____ Pay Periods) [] Monthly (____ Pay Periods)	
CONTRACT PERIOD _____ MONTHLY (9, 10, 10 ½, 12)	CAMPUS:

B - ELECTION INFORMATION

ELIGIBLE EXPENSES	PER PLAN YEAR
DEPENDENT CARE Assistant Plan (not to exceed the least of: \$5,000; your salary; your spouse's salary; or your expenses.)	\$ _____
HEALTH CARE Spending Account (not to exceed \$4,000 per plan year) <i>DO NOT INCLUDE INSURANCE PREMIUMS</i>	\$ _____

I hereby authorize my employer to make periodic salary reductions from my paycheck, to be deposited in my account, for the Election Period specified above in an amount equal to the specific dollar amounts elected for Health Care Spending Account and Dependent Care Assistant Plan. The salary reductions shall be made in substantially equal amounts to the extent administratively feasible. I further authorize CONEXIS (the UA Flexible Benefit Plan Administrator) to disburse funds from my account in accordance with the Plan and my elections. I understand that my elections cannot be altered without a qualified "Change in Status" or a qualified "Exception". I also understand that changes in my Health Care Spending Account elections will be permitted only by the reason of *death, divorce, marriage, birth or adoption*.

I understand that I must submit Dependent Care Reimbursement Requests to receive reimbursement from my Dependent Care Assistant Plan Account. I understand that I must submit Health Care Reimbursement Requests to receive reimbursement from my Health Care Spending Account.

I understand that all requests for reimbursement must be received by CONEXIS no later than March 31st of the following plan year.

I hereby verify that, if I have elected to make salary reduction contributions for the Dependent Care benefit in an amount that will exceed \$2,500 in one calendar year, and if I am married, I will file a joint income tax return with my spouse.

Participant Signature

Date

NEW HIRE INFORMATION FOR OFFICE USE ONLY	HIRE DATE:	ELIGIBILITY DATE:
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RETURN THIS FORM TO YOUR HUMAN RESOURCES OFFICE