



Premier Benefits Solutions

Post Office Box 1878 Tallahassee, Florida 32302-1878

State of Arkansas Cafeteria Plan (ARCAP)
Plan Year January 1, 2010 — December 31, 2010

Enrollment Form

Complete this enrollment form if you want to:

- Establish a tax-free Flexible Spending Account.
If you are currently enrolled in one Flexible Spending Account and want to add the other Flexible Spending Account for 2010 Plan Year, be sure to include contribution amounts for both accounts on this enrollment form.
If you participate in an HSA, you are eligible to participate in a Limited Medical Expense FSA and/or Dependent Care FSA only.
Waive tax-free premium conversion of State Employees Insurance or
Revoke a previous waiver of tax-free premium conversion of State Employees Insurance or
Waive tax-free premium conversion of eligible cancer and/or disability premiums or
Revoke a previous waiver of tax-free premium conversion of eligible Disability and/or Cancer Products.

Form with fields for Social Security #, Personnel#, Daytime Phone, Name (Last, First, MI), Home Address (Street, City, State, ZIP), Employer (Dept./Agency, Agency #, Date of Birth, Enrollment Status, Hire Date, Plan/Transfer Effective Date), and E-mail Address.

Indicate the amount you want to pay through tax-free salary reduction by completing the sections below. Complete the worksheets provided in your reference guide before deciding on the amount you wish to contribute to your FSA. If you have questions, consult your enrollment booklet or call 1-800-342-8017.

Sections A. and B. - In Box #1, indicate the total dollar amount you elect to contribute for the 2010 Plan Year, which ends December 31, 2010. In Box #2, indicate the number of regular payroll checks you expect to receive during the 2010 Plan Year\*. In Box #3, indicate the reduction amount per paycheck. (Note: If Box #3 multiplied by Box #2 does not equal Box #1 exactly, the annual amount in Box #1 may be changed slightly by the contractor due to rounding.) You must certify that you expect to receive the number of paychecks listed in Box #2.

\* Employees paid bi-weekly will receive a maximum of 26 checks for the plan year. Employees paid semi-monthly will receive 24 paychecks for the plan year.

A. Medical Expense FSA
Maximum allowable annual contribution is \$5,000.
Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 - December 31, 2010)
Box #2 Number of Regular Paychecks
Box #3 Reduction Per Regular Paycheck
NOTE: YOU WILL RECEIVE THE myFBMC CARD IF YOU ENROLL IN A MEDICAL EXPENSE FSA

A. Dependent Care FSA
Tax filing status, please check one:
Married, filing separately (maximum - \$2,500)
Single, head of household (maximum - \$5,000)
Married, filing jointly (maximum - \$5,000)
Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 - December 31, 2010)
Box #2 Number of Regular Paychecks
Box #3 Reduction Per Regular Paycheck

B. Limited Medical Expense FSA (HSA Participants Only)
Maximum allowable annual contribution is \$5,000.
Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 - December 31, 2010)
Box #2 Number of Regular Paychecks
Box #3 Reduction Per Regular Paycheck
NOTE: YOU WILL RECEIVE THE myFBMC CARD IF YOU ENROLL IN A LIMITED MEDICAL EXPENSE FSA

C. Waiver of Premium Conversion
I do not want to pay for my State Employees Insurance Premiums on a tax-free basis. I understand I will continue to pay federal, state and Social Security taxes on these premiums. (Health and Employee Life only)

D. Revocation of Waiver of Premium Conversion
I am currently paying taxes on my State Employee Insurance Premiums. I now want to pay for these premiums on a tax-free basis. I understand I will no longer pay federal, state and Social Security taxes on these premiums.

E. Waiver of Premium Conversion for Eligible Disability and Cancer Products
If you are eligible to participate in ARCAP and you have payroll deductions in effect on October 31, 2009, your eligible cancer and/or disability premiums will be converted to a tax-free status automatically, unless you check this waiver box.
I do not want to pay for my eligible cancer and/or disability insurance premiums on a tax-free basis. I understand I will continue to pay federal, state and Social Security taxes on these premiums. (See list of eligible provider companies at right.) I also understand that if I have more than one eligible disability and/or cancer plan, this waiver applies to all of them.

F. Revocation of Waiver of Premium Conversion for Eligible Disability and/or Cancer Products
I am currently paying taxes on my eligible disability and cancer premiums. I now want to pay these premiums on a tax-free basis. I understand I will not pay federal, state and Social Security taxes on these premiums.
Offered by:
American Family Life Assurance Company (AFLAC)
American Public Life Insurance Company
Colonial Life and Accident Insurance Company

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal and state income taxes and Social Security taxes are calculated by the total amount of annual salary reduction indicated above.
I understand that any contribution to an FSA may reduce my Social Security. Withholding will be based on my income after reductions.
I understand that any amount remaining in any Flexible Spending Account that is 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 account cannot be used to reimburse expenses covered by another account.
I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
I understand that the funds in the account can only be paid out to reimburse payment of expenses actually incurred during the plan year.
I understand that the amount of salary reduction 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 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 this plan or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year.
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 plans before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any other source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.
I understand that if I enroll in an HSA, I am only eligible to enroll in a Limited Medical Expense FSA and/or Dependent Care FSA.

Employee Signature Date Signed

RETURN TOP TWO COPIES TO YOUR PAYROLL/PERSONNEL OFFICE. KEEP THE BOTTOM COPY FOR YOUR RECORDS.

FBMC USE ONLY

Table with 5 columns: DATA ENTRY, VERIFICATION, SCANNED, INDEXED, SPECIAL NOTES