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 not to participate 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 not 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*

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Social Security Number

ACCEPTED BY:

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Research Foundation

Attachments

2/99