

Railroad Employees Flexible Benefits Program Election Form/Wage Reduction Agreement For 2009

Use this form if you want to have amounts deducted from your wages and contributed to either the Health Flexible Spending Arrangement (Health FSA) or the Dependent Care Assistance Program (DCAP) for 2009. Be sure to carefully read the description of each program in the Summary Plan Description and the material included with this form before making your selection. Contact UnitedHealthcare at 1-877-311-7849 if you have any questions.

Return this form (and the HIPAA authorization) in the envelope provided **no later than November 12, 2008**. If you do not return the completed form by that date, you will be deemed to have elected not to participate in the Health FSA or DCAP and will receive your full wages for the Program Year.

I elect to receive the following benefits under the Railroad Employees National Flexible Benefits Program (the Program) for the Program Year that begins January 1, 2009, and ends December 31, 2009 (*check all that apply*):

___ **Health FSA:** I elect to have a total of \$_____ deducted from my wages during the Program Year and contributed to the Health FSA, to be used for reimbursement of eligible medical care expenses as provided by the Program. (*Enter a whole dollar amount between \$120 and \$3600.*)

___ **DCAP:** I elect to have a total of \$_____ deducted from my wages during the Program Year and contributed to the DCAP, to be used for reimbursement of eligible dependent care expenses as provided by the Program. (*Enter a whole dollar amount between \$120 and \$5000. Important: You may be subject to a lesser maximum, depending on your marital and tax filing status and your spouse's earned income. Refer to the materials included with this form or contact UnitedHealthcare for further information.*)

I understand that a total amount equal to the annual contribution(s) I have selected will be deducted from my wages during the Program Year, and that these contributions will be made in installments depending on the payment system my employer uses.

I understand that the elections I am making on this form cannot be changed during 2009.

Employee: _____ SSN: _____ RRCODE: _____

Employee Signature _____ Date: _____

YOU MUST SIGN THE HIPAA AUTHORIZATION ON THE OTHER SIDE OF THIS FORM IF YOU HAVE ELECTED TO RECEIVE HEALTH FSA BENEFITS

Return this form in the envelope provided or mail to: UnitedHealthcare, 450 Columbus Blvd. Mail Code CT030-13NA, Hartford, CT 06103.

HIPAA AUTHORIZATION FOR HEALTH FSA
(January 1 to December 31, 2009)

I hereby authorize UnitedHealthcare (“UHc”), acting on behalf of The Railroad Employees National Flexible Benefits Program (“FBP”), to disclose to my employer any election I may make now or in the future to make contributions to the Health FSA component of the FBP, through wage deductions or otherwise. I understand that UHc will disclose the following individually identifiable health information to my employer: name, social security number, and the amounts I have chosen to contribute to the Health FSA. This information will be used only to determine the amount to be deducted from my wages or for other purposes related to the administration of the Health FSA component.

I understand that I can refuse to sign this authorization, in which event I shall not be entitled to participate in the Health FSA.

I understand that I may inspect or copy the information disclosed by UHc to my employer pursuant to this authorization.

I understand that I may revoke this authorization at any time by notifying UHc in writing, except to the extent action has been taken in reliance on this authorization.

I understand that I have a right to request and receive a Notice of Privacy Practices from the FBP.

I understand that information disclosed to my employer is no longer protected by the federal medical information privacy rule issued pursuant to the Health Insurance Portability and Accountability Act.

This authorization expires on January 1, 2010.

Employee Signature _____ Date: _____