ROBINS & MORTON

2024 Salary Benefits Enrollment Form

Please complete this form in order to enroll in benefits. Your elections will be entered in the system for you.
Email the form to rmenroll@robinsmorton.com or fax the form to 205-803-0102.

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: ____ - ____ - _____ Email Address: _____

Phone Number: _____ Alternate Phone: _____

In the section below, please enter all dependents and/or beneficiaries who will be covered in your benefits.
In the column Type, please list "D" for dependents, "B" for beneficiary, or "Z" if the person is both a dependent and beneficiary.

DEPENDENTS/BENEFICIARIES

Name	Type	Relationship	SSN	DOB	Gender

You will automatically be enrolled in this company provided benefit. Please provide a beneficiary below.
Please select whether they are a primary beneficiary or contingent beneficiary and what percentage you are allocating to them.

BENEFICIARY NAME	PRIMARY %	CONTIGENT %
Ex: Joe Construction	*100%*	
Ex: Jill Construction		*100%*

Medical Insurance

SAVER

☐ Waive Saver Plan

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Please indicate which dependents should be covered by medical insurance:

NAME	

CATASTROPHIC

☐ Waive Catastrophic Plan

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Please indicate which dependents should be covered by medical insurance:

NAME	

HEALTH SAVINGS ACCOUNT

If you have signed up for a medical plan, you are eligible for a health savings account. After your enrollment has been processed, you will need to open your account and manage your contributions with Fidelity at www.401k.com.

☐ Waive Health Savings Account

DEPENDENT CARE ACCOUNT

☐ Waive Dependent Care Account

Amount:_____ per week ($5,000 annual maximum)

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (vision and dental expenses only)

☐ Waive Flexible Spending Account

Amount: _____ per week ($3,200 annual maximum)

DENTAL INSURANCE

☐ Waive Dental Plan

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Please indicate which dependents should be covered by dental insurance:

NAME	

VISION INSURANCE

☐ Waive Vision Plan

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Please indicate which dependents should be covered by vision insurance:

NAME	

Optional Life Insurance

EMPLOYEE OPTIONAL LIFE INSURANCE

In addition to Company Paid Life Insurance, you may enroll in additional life insurance. Please select your coverage tier below. Please select whether they are a primary beneficiary or contingent beneficiary and what percentage you are allocating to them. **If elected, new hires must start at $25,000 coverage.**

☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $200,000

BENEFICIARY NAME	PRIMARY %	CONTIGENT %
Ex: Joe Construction	*100%*	
Ex: Jill Construction		*100%*

SPOUSE OPTIONAL LIFE INSURANCE

In addition to Company Paid Life Insurance, you may enroll in additional life insurance. Please select your coverage tier below. Please select whether they are a primary beneficiary or contingent beneficiary and what percentage you are allocating to them. **If elected, new hires must start at $10,000 coverage for spouses.**

☐ $10,000 ☐ $25,000 ☐ $50,000

BENEFICIARY NAME	PRIMARY %	CONTIGENT %
Ex: Joe Construction	*100%*	
Ex: Jill Construction		*100%*

CHILD OPTIONAL LIFE INSURANCE

In addition to Company Paid Life Insurance, you may enroll in additional life insurance. Please select your coverage tier below. Please select whether they are a primary beneficiary or contingent beneficiary and what percentage you are allocating to them.

☐ $10,000

BENEFICIARY NAME	PRIMARY %	CONTIGENT %
Ex: Joe Construction	*100%*	
Ex: Jill Construction		*100%*

LONG TERM DISABILITY

☐ Employee paid
☐ Employer paid

METLIFE ACCIDENT INSURANCE

You can elect this for yourself, your spouse, or your child(ren). Please indicate the plan level of coverage, who is covered, and the beneficiaries of the policies.

☐ Waive MetLife Accident Insurance

Level of Election - Accident Plan

☐ Low Plan ☐ High Plan

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

BENEFICIARY NAME	PRIMARY %	CONTIGENT %
Ex: Joe Construction	*100%*	
Ex: Jill Construction		*100%*

METLIFE INDEMNITY INSURANCE

☐ Waive MetLife Indemnity Insurance

Level of Election - Indemnity Plan

☐ Low Plan ☐ High Plan

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Please indicate which dependents should be covered by indemnity insurance:

NAME	

I understand Robins & Morton has offered the benefits on this enrollment form and acknowledge my selections.

Name: _____ Date: _____