FOR OFFICE USE ONLY:

Date Received: _____ Date Entered: _____

Entered by: _____ Username/Password: _____

Hourly Benefit Enrollment Form

Please complete this form and your elections will be entered in the system for you. You may return the completed form to the jobsite, email 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 Number _____

In the section below, please enter all dependents which will be covered in your benefits. If you need additional space, please add a page to this form. Do not include any dependent below that will not be covered.

MEDICAL INSURANCE

☐ WAIVE Medical Insurance

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family

COVERED DEPENDENTS

NAME	RELATIONSHIP	GENDER	SSN	DOB	ADDRESS	CITY	STATE	ZIP

All dependents MUST have a social security number to be enrolled.

HEALTH SAVINGS ACCOUNT

Open your account and manage your contributions with Fidelity at www.401k.com

☐ WAIVE Health Savings Account Contribution

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

DISCLAIMER: Use it or lose it, and can only be used for dental and vision expenses.

☐ WAIVE Limited Purpose Flexible Spending Account Contribution

Amount: _____ per week ($3,400 maximum yearly contribution or $65.38 weekly maximum).

DEPENDENT CARE ACCOUNT

☐ WAIVE Dependent Care Flexible Spending

Amount:_____ per week (maximum of $7,500.00 annually)

Please list the dependents to be covered by the dependent care flexible spending account:

Name	

DENTAL INSURANCE

☐ WAIVE Dental Benefit

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family

Please indicate which dependents listed above should be covered by dental insurance:

Name	

VISION INSURANCE

☐ WAIVE Vision Benefit

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family

Please indicate which dependents listed above should be covered by vision insurance:

Name	

SHORT TERM DISABILITY INSURANCE

☐ WAIVE Short Term Disability

☐ ELECT Short Term Disability

LONG TERM DISABILITY INSURANCE

☐ WAIVE Long Term Disability

☐ ELECT Long Term Disability

ACCIDENT INSURANCE

You can elect insurance on yourself, your spouse and your child(ren). Please indicate the plan level of coverage, who is covered then the beneficiaries of the policy.

☐ WAIVE Accident Insurance

Level of Election—Accident Plan:

☐ Low Plan ☐ High Plan

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Family

Dependent Covered	Beneficiary	Primary %	Contingent %	SSN	DOB
You					
Your dependent					

INDEMNITY INSURANCE

☐ WAIVE Hospital Indemnity Insurance

Level of Election—Indemnity Plan:

☐ Low Plan ☐ High Plan

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Family

Please indicate which dependents listed above 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:_____