RPI ENROLLMENT / CHANGE- Benefits Election Form

Social Security Number	RIN (Employee Number)	Name: Last First MI

- **Please select the plans and coverage levels that you would like to participate in.**

Long Term Disability Insurance (Select One)
☒ Replace 60% of basic monthly earnings up to $5,000 (free for regular full-time employees)
☐ Replace 66 2/3% of basic monthly earnings up to $7,500 ($0.21/$100)

Health Care Flexible Spending Account
(Maximum Annual Contribution is $3,000)
Annual Election: $

Dependent Care Flexible Spending Account
(Maximum Annual Contribution is $5,000)
Annual Election: $

Employee Supplemental Life Insurance
☐ Specific Amount $______________(Increments of $10,000 - Limited to 4.5 times pay) ☐ Waive coverage

Spousal and Dependent Supplemental Life
(Must elect coverage on yourself)
☐ $10,000 for your spouse and $2,000 for each of your children ☐ Waive coverage

Employee Supplemental AD&D
You may elect increments of $10,000 up to $350,000 or 10 times annual earnings, whichever is less

Amount Requested: $ _______________________

Spousal Supplemental AD&D
☐ 100% ☐ 50% (of employee supplemental AD&D election)
☐ Waive coverage

Dependent Supplemental AD&D
☐ 10% (of employee supplemental AD&D election)
☐ Waive coverage

Special Enrollment Rights: *If you are declining coverage in the Medical component of the plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your spouse or your dependents in the plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.* ***Acceptance:*** *I hereby apply, on behalf of myself and each dependent listed above, for the coverage elected. I understand that coverage will be provided according to the terms and conditions of the contract between the insurance carrier(s) and my employer. I hereby authorize any physician, hospital or other provider of service to furnish any information, reports or copies of records, related to care or services rendered to me or any of the dependents listed above to the insurance carrier(s) or other third parties who require such information to administer the plan. Such information is to be held confidential. I understand that by completing and signing this enrollment form, I am making a binding election with regard to my benefits and that I am authorizing my employer to make the deductions necessary to pay my share of the cost of coverage. I further understand that I cannot cancel or change this election unless I experience a Change-in-Status or am entitled to a Special Enrollment Right. I also authorize subsequent payroll deductions in future plan years unless I notify my employer of a change in my election.*

Employee Signature____Date _________________________

HR Use Only	Date Entered Into Banner	Initial	
Deduction Code:	Payroll Effective Date:	Arrears:	Benefit Effective Date-Reference:
Deduction Code:	Payroll Effective Date:	Arrears:	Benefit Effective Date-Reference:
Deduction Code:	Payroll Effective Date:	Arrears:	Benefit Effective Date-Reference: