



Eder Financial

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2027 Budget Worksheet

Long-Term Disability

Please fill out this form. You may submit this worksheet via email, fax, or U.S. mail.

ACCOUNT INFORMATION

Employer Name _____ Agreement No. or Church Code _____

Employee Last Name _____ First Name _____ MI _____

Employee Address _____

City _____ State _____ ZIP _____

Telephone _____ Email _____

We will use your email solely to communicate with you about Eder Health & Life Benefits.

LTD PREMIUM CALCULATION

NOTE: Coverage amount is based on this information. Please submit a new form annually and any time there is a salary and/or parsonage adjustment amount change.

Salary Effective Date _____ Hours worked per week _____
(minimum required = 16 hr/wk)

A. **Your base annual cash salary (Do not prorate)** A. _____

B. **Parsonage Adjustment Amount OR Parsonage Fair Rental Value **** B. _____

**** If there is NO parsonage, enter the parsonage adjustment amount (this amount equals the average cost of renting a three-bedroom home in congregation's zip code) OR if a parsonage IS available, enter the fair rental value (the estimated value of renting the parsonage.)
This is for clergy only.**

C. **Total (A) + (B) (Maximum covered salary is \$90,000)** C. _____

D. **Divide (C) by \$100** D. _____

E. **Multiply (D) by 0.70 (This is your annualized LTD premium)** E. _____

F. **Divide (E) by 12 (This is your monthly LTD premium)** F. _____

SIGNATURES

*I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being void as of its effective date with no benefits payable. I hereby request the group insurance coverage for which I am or may become eligible and authorize deductions from my earnings to serve as payment for any required contributions. My signature below affirms that all information and statements provided on this form are full, complete, and true to the best of my knowledge. **Fraud Warning Notice:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

Signature of Employee

Date

Signature of Employer

(church board chair, district executive, treasurer, or other authorized employer representative)

Date