Eder Financial
BOLD. BALANCED. TRUSTED.

1505 Dundee Avenue • Elgin, Illinois 60120-1619
800-746-1505 • 847-695-0200 • Fax 847-742-6336
insurance@eder.org • www.ederfinancial.org

# 2022 Budget Worksheet
## Long-Term Disability

**Please fill out this form. You may submit this worksheet via email, fax, or US 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 address solely to communicate with you about Eder Health and 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 housing allowance change.

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

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

**B. Housing Allowance (includes utilities)** ..... **B.** _____
(If you use a parsonage, use 20 percent of (A), or rental value of parsonage.)

**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* *Date*

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