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

2027 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)