Eder Financial
BOLD. BALANCED. TRUSTED.
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2027 Budget Worksheet

Short-Term Disability

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

ACCOUNT INFORMATION

Employer Name _____

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.

STD PREMIUM CALCULATION

Benefit covers 60 percent of weekly earnings (up to $1,250 per week max).

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)** (If you use a parsonage, use 20 percent of (A), or rental value of parsonage.)	**B.**_____
C.	**Total (A)+(B) (must be at least $15,000) (maximum covered salary is $108,316)**	**C.**_____
D.	**Divide (C) by 52 (not to exceed $2,083)**	**D.**_____
E.	**Multiply (D) by 0.60**	**E.**_____
F.	**Multiply (E) by (rate according to your age bracket in table to the right)**	**F.**_____
G.	**Divide the amount on line (F) by 10 (this is your monthly premium)**	**G.**_____
H.	**Multiply line (G) by 12 (this is your annualized premium)**	**H.**_____

Age	Rate per $10 Weekly Benefit
Under 25	$0.39
25–29	$0.43
30–34	$0.43
35–39	$0.38
40–44	$0.37
45–49	$0.43
50–54	$0.55
55–59	$0.63
60–64	$0.70
65–69	$0.85
70+	$1.09

Rates will automatically adjust based on age.

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)