|  |
| --- |
| **Last Name First Name SSN DOB** |

**RATES LISTED PER MONTH**

**PRE-TAX AFTER-TAX**

**LIFE INSURANCE (AETNA)**

***Employee ($25,000 Incl. AD&D) – DISTRICT PAID* *$5.13***

Dependent Life (Spouse $10,000/Children $5,000) - $4.15 xxxxxxx

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ­­­***GROUP HEALTH INSURANCE (ASBAIT) + TELEDOC*** | **Employee** | **Employee + Spouse** | **Employee  + Child(ren)** | **Employee + Family** |  |  |  |
| Banner Co-Pay Gold | $631.00 | $1,265.00 | $1,194.00 | $1,741.00 |  |  |  |
| Banner Classic Gold | $575.00 | $1,151.00 | $1,086.00 | $1,584.00 |  |  |  |
| ***Banner Value Gold*** | ***$517.00*** | $1,038.00 | $980.00 | $1,429.00 |  |  |  |
|  |  |  |  |  |  |  |  |
| ***VISION*** |  |  |  |  |  |  |  |
| ***ASBAIT Open Access*** | ***$6.40*** | $12.70 | $12.70 | $17.90 |  |  |  |
| ***DENTAL*** |  |  |  |  |  |  |  |
| PPO | $47.60 | $95.10 | $97.50 | $134.10 |  |  |  |
| ***EDS Discount Plan*** | ***$11.48*** | $22.85 | $22.85 | $31.11 |  |  |  |

**VOLUNTARY SUPPLEMENTAL (AFLAC)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***CANCER*** | | | |  | |  | |  | |  | |  |  |  |
| Option 1 (formerly Select) | | | | $23.45 | | $41.31 | | $23.45 | | $41.31 | |  |  |  |
| Option 2 (formerly Classic) | | | | $40.36 | | $72.60 | | $40.36 | | $72.60 | |  |  |  |
| ***HOSPITAL INSURANCE*** | | | |  | |  | |  | |  | |  |  |  |
| Base Plan - 1000\* Starting at: | | | | $26.78 | | $37.83 | | $33.93 | | $40.17 | |  |  |  |
| Extended Benefits Rider | | | | $11.57 | | $24.18 | | $23.01 | | $29.38 | |  |  |  |
| Hospital Stay & Surgical Care Rider | | | | $18.20 | | $33.28 | | $25.22 | | $33.93 | |  |  |  |
| ***ACCIDENT INSURANCE*** | | | |  | |  | |  | |  | |  |  |  |
| Level 2 | | | | $17.29 | | $24.57 | | $29.25 | | $38.22 | |  |  |  |
| Level 4 | | | | $25.09 | | $35.88 | | $43.03 | | $56.16 | |  |  |  |
| Additional Riders | | | |  | |  | |  | |  | |  |  |  |
| ***CRITICAL CARE & RECOVERY*** | | | |  | |  | |  | |  | |  |  |  |
| Plan 2\* - Starting at: | | | | $19.89 | | $38.61 | | $31.85 | | $43.16 | |  |  |  |
| ***DISABILITY INCOME GUARANTEED ISSUE*** | | | | | **3 Month** | | | | **6 Month** | |  |  |  |  |
| Elimination Period: | | | | |  | | Units: | |  | |  |  |  |  |
| **OTHER -** | | | | |  | | **AFLAC ICU \_\_\_\_\_\_\_\_\_** | |  | |  |  |  |  |
| ***DEPENDENT CARE REIMBURSEMENT ($5,000 MAX)*** | | | | |  | | | |  | |  |  |  |  |
| \*Rates depend on age and coverage selected |  |  | | | |  | | Total Monthly: | | | |  |  |  |
|  | | |  | |  |  | | District Allowance: | | | |  |  |  |
|  | | |  | |  |  | | Balance: | | | |  |  |  |
|  | | |  | |  |  | | EE Deduction Total: | | | |  |  |  |

For payroll deduction, I hereby authorize my employer to deduct from my earnings such amounts as may now or hereafter be payable by me through the above-insured plans. In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next anniversary date, unless due to a change in family status and permitted by my employer. **WAIVED EMPLOYEES: RECEIVE VISION, EDS DENTAL & TELEDOC AND MUST PROVIDE PROOF OF MEDICAL COVERAGE.**

**Date Signature Enroller**