|  |
| --- |
| **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**