COOLIDGE UNIFIED SCHOOL DISTRICT

EMPLOYEE BENEFITS SELECTION FORM

For Plan Year July 1, 2025 to June 30, 2026

Last Name , First Name Social Security Number Date of Birth

RATES BASED ON 20 PAY PERIODS (10 months)

Pre-Tax / After Tax

AFLAC SHORT TERM DISABILITY (A)

Example – Annual Salary	**$16,000**	**$20,000**	**$28,000**	**$34,000**
Aflac Monthly Benefit	$800	$1,000	$1,400	$1,700
Employee Only (18-49)	$ 9.36	$11.70	$16.38	$19.89
Employee Only (50-64)	$11.23	$14.04	$19.66	$23.87
Employee Only (65-74)	$14.35	$17.94	$25.12	$30.50

Quote is for 6 months, 14 day wait for off the job accident, 14 day wait for illness

Amount: _____	**Months: _____**	**Wait: ___/___**	**xxxxxxxxx**	

AFLAC ACCIDENT INSURANCE (A –1)	**Ages: 18-75**		
Employee	$11.64		
Additional for Spouse	$ 4.96		
Additional for Child(ren)	$ 8.06		
Additional for Family	$14.10		

AFLAC CANCER (S-5)	**Ages: 18-75**		
Employee - includes child(ren)	$23.67		
Additional for spouse/family	$19.14		

AFLAC HOSPITAL CHOICE(1-1000)	**Ages:**	**60-75**	**50-59**	**18-49**		
Employee		$16.85	$16.38	$ 16.07		
Additional for Spouse		$ 8.89	$ 7.65	$ 6.63		
Additional for Child(ren)		$ 4.13	$ 4.29	$ 4.29		
Additional for Family		$ 9.20	$ 7.96	$ 8.03		

TOTAL PURCHASES: _____ _____

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 insurance 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. Execution of this form DOES NOT imply coverage. An application MUST be written and a policy MUST be issued.

_____ _____

Date Signature