COOLIDGE UNIFIED SCHOOL DISTRICT

EMPLOYEE BENEFITS SELECTION FORM

For Plan Year July 1, 2023 hru June 30, 2024

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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 (A –2)	Ages: 18-75		
Employee	$10.38		
Additional for Spouse	$ 4.36		
Additional for Child(ren)	$ 7.17		
Additional for Family	$12.55		

AFLAC CANCER PROTECTION ASSURANCE (2-5)	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