CHURCH OF THE BRETHREN
INSURANCE SERVICES

A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
1505 Dundee Avenue • Elgin, Illinois 60120-1619
800-746-1505 • 847-695-0200 • Fax 847-742-6336
insurance@cobbt.org • www.bbtinsurance.org

2021 Budget Worksheet

Short-Term Disability

Please keep a completed copy for your records.

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 Brethren Insurance Services.

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)** B.____________
(If you use a parsonage, use 20 percent of (A), or rental value of parsonage.)

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
18-24	$0.16
25-29	$0.17
30-34	$0.17
35-39	$0.15
40-44	$0.13
45-49	$0.15
50-54	$0.15
55-59	$0.16
60-64	$0.16
65-69	$0.18
70+	$0.21

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)