

Premium Worksheet



Rates and/or benefits may be changed on a class basis.

VOLUNTARY HOSPITAL INDEMNITY INSURANCE		
Monthly Premium Amount (Cost per Pay Period – 12/Year)		
COVERAGE TIER	PLAN 1	PLAN 2
Employee Only	\$12.53 (\$0.41 per day)	\$24.31 (\$0.80 per day)
Employee & Spouse	\$23.17 (\$0.76 per day)	\$44.89 (\$1.48 per day)
Employee & Child(ren)	\$20.97 (\$0.69 per day)	\$40.72 (\$1.34 per day)
Employee & Family	\$33.17 (\$1.09 per day)	\$64.37 (\$2.12 per day)

5962h NS 07/21 Hospital Income Plan Form Series includes GBD-2800, GBD-2900, or state equivalent.

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