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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