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**
Employee Only	**$19.28** ($0.63 per day)
Employee & Spouse/Partner	**$33.00** ($1.08 per day)
Employee & Child(ren)	**$26.54** ($0.87 per day)
Employee & Family	**$47.74** ($1.57 per day)

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

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