

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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