

# Premium Worksheet



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

<b>VOLUNTARY HOSPITAL INDEMNITY INSURANCE</b>	
<b>Monthly Premium Amount (Cost per Pay Period – 12/Year)</b>	
<b>COVERAGE TIER</b>	<b>PLAN 1</b>
Employee Only	<b>\$30.76</b> (\$1.01 per day)
Employee & Spouse/Partner	<b>\$56.81</b> (\$1.87 per day)
Employee & Child(ren)	<b>\$46.84</b> (\$1.54 per day)
Employee & Family	<b>\$91.11</b> (\$3.00 per day)

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

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