Premium Worksheet

Rates and/or benefits may be changed on a class basis. Rates are based on the employee's age and increase as you enter each new age category.

VOLUNTARY CRITICAL ILLNESS INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

Benefit Amount	Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
$10,000	Employee Only	$3.79	$4.60	$5.14	$6.48	$8.97	$13.73	$19.00	$25.87	$36.30	$49.68	$66.71	$88.95	$107.21
	Employee & Spouse/Partner	$7.55	$9.12	$10.20	$12.87	$17.96	$27.90	$38.97	$53.46	$75.33	$102.72	$137.86	$183.04	$220.30
	Employee & Child(ren)	$5.74	$6.55	$7.09	$8.43	$10.92	$15.68	$20.95	$27.82	$38.26	$51.63	$68.66	$90.91	$109.17
	Employee & Family	$9.83	$11.40	$12.48	$15.14	$20.23	$30.17	$41.24	$55.73	$77.61	$105.00	$140.14	$185.32	$222.58
$20,000	Employee Only	$6.62	$8.15	$9.19	$11.84	$16.72	$26.14	$36.61	$50.24	$70.99	$97.56	$131.52	$175.90	$212.38
	Employee & Spouse/Partner	$13.21	$16.18	$18.25	$23.53	$33.51	$53.14	$75.13	$103.89	$147.38	$201.79	$271.83	$361.95	$436.39
	Employee & Child(ren)	$9.66	$11.19	$12.23	$14.88	$19.76	$29.18	$39.65	$53.28	$74.03	$100.61	$134.56	$178.94	$215.42
	Employee & Family	$16.75	$19.73	$21.79	$27.07	$37.05	$56.69	$78.67	$107.44	$150.93	$205.34	$275.37	$365.50	$439.94

5962f NS 07/21 Critical Illness Form Series includes GBD-1700, GBD-1701, or state equivalent.

VOLUNTARY ACCIDENT INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

COVERAGE TIER	Plan Coverage
Employee Only	**$10.70** ($0.35 per day)
Employee & Spouse/Partner	**$16.86** ($0.55 per day)
Employee & Child(ren)	**$17.90** ($0.59 per day)
Employee & Family	**$28.16** ($0.93 per day)

5962g NS 07/21 Accident Form Series includes GBD-2000, GBD-2300, or state equivalent.

VOLUNTARY HOSPITAL INDEMNITY INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

COVERAGE TIER	Plan Coverage
Employee Only	**$18.34** ($0.60 per day)
Employee & Spouse/Partner	**$35.83** ($1.18 per day)
Employee & Child(ren)	**$31.05** ($1.02 per day)
Employee & Family	**$50.64** ($1.66 per day)

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

CREATION DATE: 4/16/2023
LIMRICC/00152985

FORM PA-10155 (2017)