

PREMIUM WORKSHEET



Rates and/or benefits can change. Rates are based on the employee's age and increase as you enter each new age category.

VOLUNTARY SHORT TERM DISABILITY INSURANCE												
Monthly Premium Amount (Cost per Pay Period – 12/Year)												
Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Option 1 Rates	\$0.6760	\$0.8990	\$0.9900	\$0.7740	\$0.6250	\$0.6390	\$0.7700	\$0.9530	\$1.1450	\$1.2300	\$1.2300	\$1.2300
Option 2 Rates	\$0.3740	\$0.4880	\$0.5410	\$0.4350	\$0.3640	\$0.3750	\$0.4520	\$0.5610	\$0.6740	\$0.7230	\$0.7230	\$0.7230

To calculate your monthly premium amount, use the following formula.

$$\frac{\text{Your Annual Earnings}}{52} = \text{Your Weekly Earnings} \times 60\% = \frac{\text{Weekly Benefit}}{\text{Max} = \$2,000} \div 10 = \text{Rate} \times \text{Rate} = \text{Premium Amount}$$

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VOLUNTARY CRITICAL ILLNESS INSURANCE													
Monthly Premium Amount (Cost per Pay Period – 12/Year)													
Benefit Amount	Coverage Tier	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
\$5,000	Employee Only	\$1.42	\$1.69	\$1.87	\$2.29	\$3.07	\$4.53	\$6.13	\$8.21	\$11.36	\$15.41	\$20.59	\$27.35
	Employee & Spouse/Partner	\$2.39	\$2.81	\$3.10	\$3.73	\$4.93	\$7.22	\$9.70	\$12.93	\$17.82	\$23.98	\$31.90	\$42.16
	Employee & Child(ren)	\$2.80	\$2.99	\$3.01	\$3.34	\$4.04	\$5.49	\$7.06	\$9.14	\$12.29	\$16.33	\$21.51	\$28.28
	Employee & Family	\$4.01	\$4.33	\$4.43	\$4.95	\$6.07	\$8.33	\$10.79	\$14.02	\$18.89	\$25.05	\$32.98	\$43.24
\$20,000	Employee Only	\$3.93	\$4.90	\$5.57	\$7.20	\$10.19	\$15.94	\$22.31	\$30.61	\$43.24	\$59.41	\$80.12	\$107.20
	Employee & Spouse/Partner	\$6.17	\$7.61	\$8.62	\$11.07	\$15.63	\$24.52	\$34.39	\$47.30	\$66.85	\$91.47	\$123.17	\$164.20
	Employee & Child(ren)	\$7.93	\$8.54	\$8.58	\$9.86	\$12.53	\$18.20	\$24.49	\$32.77	\$45.37	\$61.54	\$82.25	\$109.33
	Employee & Family	\$10.83	\$11.86	\$12.13	\$14.17	\$18.35	\$27.16	\$36.93	\$49.82	\$69.32	\$93.95	\$125.65	\$166.67

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VOLUNTARY HOSPITAL INDEMNITY INSURANCE		
Monthly Premium Amount (Cost per Pay Period – 12/Year)		
COVERAGE TIER	Plan 1	Plan 2
Employee Only	\$13.77 (\$0.45 per day)	\$21.67 (\$0.71 per day)
Employee & Spouse/Partner	\$28.58 (\$0.94 per day)	\$44.55 (\$1.46 per day)
Employee & Child(ren)	\$25.55 (\$0.84 per day)	\$39.19 (\$1.29 per day)
Employee & Family	\$42.07 (\$1.38 per day)	\$64.62 (\$2.12 per day)

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This document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

