



CITY OF FORT LAUDERDALE

VOLUNTARY BENEFITS RATE SHEET



Legal Insurance (post-tax)

BI-WEEKLY PREMIUMS		
Coverage	UltimateAdvisor	UltimateAdvisor Plus
Family	\$8.42	\$10.15

Group Accident Insurance* (pre-tax)

COVERAGE	BI-WEEKLY PREMIUM
Employee	\$8.01
Employee & Spouse	\$13.38
Employee & Child(ren)	\$16.88
Family	\$22.25

Group Critical Illness Insurance* (pre-tax)

EMPLOYEE NON-TOBACCO BI-WEEKLY PREMIUMS			
Age	Coverage Amount		
	\$10,000	\$20,000	\$30,000
18-25	\$1.83	\$3.01	\$4.19
26-30	\$2.33	\$4.02	\$5.70
31-35	\$2.66	\$4.67	\$6.68
36-40	\$3.38	\$6.11	\$8.85
41-45	\$4.03	\$7.41	\$10.80
46-50	\$4.77	\$8.88	\$13.00
51-55	\$7.23	\$13.82	\$20.40
56-60	\$7.05	\$13.46	\$19.86
61-65	\$14.28	\$27.91	\$41.55
66+	\$25.08	\$49.50	\$73.93

SPOUSE NON-TOBACCO BI-WEEKLY PREMIUMS			
Age	Coverage Amount		
	\$5,000	\$10,000	\$15,000
18-25	\$1.24	\$1.83	\$2.42
26-30	\$1.49	\$2.33	\$3.18
31-35	\$1.66	\$2.66	\$3.67
36-40	\$2.02	\$3.38	\$4.75
41-45	\$2.34	\$4.03	\$5.72
46-50	\$2.71	\$4.77	\$6.82
51-55	\$3.94	\$7.23	\$10.52
56-60	\$3.85	\$7.05	\$10.26
61-65	\$7.47	\$14.28	\$21.10
66+	\$12.86	\$25.08	\$37.29

* All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms. Final rates will be included in your confirmation statement when your enrollment is complete.



Group Critical Illness Insurance* (pre-tax, continued)

EMPLOYEE TOBACCO BI-WEEKLY PREMIUMS			
	Coverage Amount		
Age	\$10,000	\$20,000	\$30,000
18-25	\$2.36	\$4.07	\$5.79
26-30	\$3.05	\$5.46	\$7.86
31-35	\$3.75	\$6.86	\$9.96
36-40	\$5.00	\$9.34	\$13.69
41-45	\$5.97	\$11.29	\$16.61
46-50	\$7.10	\$13.54	\$19.99
51-55	\$11.05	\$21.46	\$31.86
56-60	\$11.17	\$21.68	\$32.20
61-65	\$22.12	\$43.58	\$65.05
66+	\$38.02	\$75.40	\$112.77

SPOUSE TOBACCO BI-WEEKLY PREMIUMS			
	Coverage Amount		
Age	\$5,000	\$10,000	\$15,000
18-25	\$1.51	\$2.36	\$3.22
26-30	\$1.85	\$3.05	\$4.26
31-35	\$2.20	\$3.75	\$5.30
36-40	\$2.82	\$5.00	\$7.17
41-45	\$3.31	\$5.97	\$8.63
46-50	\$3.87	\$7.10	\$10.32
51-55	\$5.85	\$11.05	\$16.25
56-60	\$5.91	\$11.17	\$16.43
61-65	\$11.38	\$22.12	\$32.85
66+	\$19.34	\$38.02	\$56.71

Group Hospital Indemnity Insurance* (post-tax)

HOSPITAL INDEMNITY INSURANCE - MID		HOSPITAL INDEMNITY INSURANCE - HIGH	
Coverage	BI-WEEKLY Premium	Coverage	BI-WEEKLY Premium
Employee	\$8.25	Employee	\$14.58
Employee & Spouse	\$15.73	Employee & Spouse	\$29.40
Employee & Child(ren)	\$12.54	Employee & Child(ren)	\$23.05
Family	\$20.02	Family	\$37.87

Group Short-Term Disability Insurance* (post-tax)

BI-WEEKLY PREMIUM PER UNIT (\$100 OF MONTHLY BENEFIT)			
Age	7/7 EP 3 Mo Period	7/7 EP 6 Mo Period	90/90 EP 12 Mo Period
18-49	\$1.02	\$1.26	\$0.48
50-64	\$1.02	\$1.38	\$0.66
65-74	\$1.26	\$1.74	\$0.96

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