City of Rock Island

2027 Insurance Premiums Pre-Tax Enrollment Form

Employee Name: _____
(Please Print)

BCBS of Illinois Medical PPO Plan

Premiums per period (26 per year):

_____ Employee	$113.21
_____ Employee/Spouse	$226.42
_____ Employee/Child	$215.10
_____ Family	$315.86
_____ Waive Medical Coverage	

Delta Dental of Illinois Plan

Low Plan ($1000 Maximum) Premiums per pay period:

_____ Employee	$11.97
_____ Employee/Spouse	$23.94
_____ Employee/Child	$29.56
_____ Family	$47.05
_____ Waive Dental Coverage	

High Plan ($2000 Maximum) Premiums per pay period:

_____ Employee	$13.80
_____ Employee/Spouse	$27.59
_____ Employee/Child	$36.36
_____ Family	$55.44
_____ Waive Dental Coverage	

Avesis Vision Plan

Premiums per period (26 per year):

_____ Employee	$4.25
_____ Employee/Spouse	$8.15
_____ Employee/Child	$8.88
_____ Family	$11.44
_____ Waive Vision Coverage	

Note: These premiums will be taken out as pre-tax deductions on your paycheck. If you would like the deductions taken out on a **post-tax basis**, please **check here**: _____

Signature: _____ Date: _____