# City of Rock Island

## 2026 Insurance Premiums Pre-Tax Enrollment Form

**Employee Name:** _____

(Please Print)

### BCBS of Illinois Medical PPO Plan

**Premiums per period (26 per year):**

| | |
|---|---|
| _____ Employee | $104.34 |
| _____ Employee/Spouse | $208.68 |
| _____ Employee/Child | $198.25 |
| _____ Family | $291.11 |
| _____ 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: _____