Exhibit 2

Form of Cost Proposal
Decatur Housing Authority
Health Insurance and Benefits Program
January 2018

	Match Existing Coverage Option		
MEDICAL and RX	**Monthly Premium**		
	year 1	**year 2**	**year 3**
Employee			
Employee & Spouse			
Employee & Child			
Family			
DENTAL	**Monthly Premium**		
	year 1	**year 2**	**year 3**
Employee			
Employee & Spouse			
Employee & Child			
Family			
VISION	**Monthly Premium**		
	year 1	**year 2**	**year 3**
Employee			
Employee & Spouse			
Employee & Child			
Family			
SHORT TERM	**Monthly Premium**		
DISABILITY	**year 1**	**year 2**	**year 3**
Employee			
Employee & Spouse			
Employee & Child			
Family			

Please identify and list all applicable fees or costs not included in monthly premiums.

OTHER FEES/CHARGES	**ANNUAL FEES**		
	year 1	**year 2**	**year 3**
TOTAL			

Form of Cost Proposal
Decatur Housing Authority
Health Insurance and Benefits Program
January 2018

HEALTH SAVINGS ACCOUNT	**year 1**	**year 2**	**year 3**
Recommended funding			
HAS Admin Fees and costs			
Stop loss Premium			

Submitted by:

Company Name ____________________

Company Addreess ____________________

Company Phone ____________________

E-mail contact ____________________

The offeror hereby acknowledges receipt of Addendums No. ______ ______ ______ ______