Location Remittance (September 2014 Trial Invoice)

Previous Total Due	Total Payments	Unpaid Balance	Current Premium	Payment Due Date
$0.00	$0.00	$0.00	$363,847.85	09/30/2014

Location	Policy Number	Prepared	Billing Period	Remit Payment to:
Sample Plan Sponsor	1234	09/18/2014	September 2014 Trial Invoice	General Board of Pension and Health Benefits ATTENTION: Accounts Receivable-HealthFlex P.O. Box 75783 Chicago, IL 60675-5783
PLEASE PAY THIS AMOUNT				$362,750.05

Coverage	Enrolled	Current Premium	Credit Premium	Debit Premium	Total Premium
Dental	1	$22,723.00	$0.00	$0.00	$22,723.00
Flexible Spending Medical	1	$13,684.67	$0.00	$0.00	$13,684.67
Flexible Spending Dependent	1	$15,967.46	$0.00	$0.00	$15,967.46
Medical	2	$306,855.00	$0.00	$0.00	$306,855.00
Medical-Dep Only	1	$2,601.00	$0.00	$0.00	$2,601.00
Vision	3	$2,016.72	$0.00	$0.00	$2,016.72
Total Premium		$363,847.85	$0.00	$0.00	$363,847.85

Totals with Adjustments

Other	
Pension Deduction	-$1,097.80
	-$1,097.80

Previous Total Due	$0.00
Total Payments Received	$0.00
Unpaid Balance	$0.00
Current Premium	$363,847.85
Credit Premium	$0.00
Debit Premium	$0.00
Other	-$1,097.80
Current Total Due	$362,750.05