

**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
<b>PLEASE PAY THIS AMOUNT</b>				<b>\$362,750.05</b>	

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
<b>Total Premium</b>		<b>\$363,847.85</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$363,847.85</b>

Totals with Adjustments				
Other			Previous Total Due	\$0.00
	Pension Deduction	-\$1,097.80	Total Payments Received	\$0.00
		-\$1,097.80	Unpaid Balance	\$0.00
			Current Premium	\$363,847.85
			Credit Premium	\$0.00
			Debit Premium	\$0.00
			Other	-\$1,097.80
			Current Total Due	<b>\$362,750.05</b>