



PREMIUM INVOICE

Invoice Number:
Billing Date:
Due Date:

INSURANCE PROVIDER

Company Name:
Address:
Phone:
Email:
GROUP POLICYHOLDER (BILL TO)

Group Name:
Group Policy ID:
Billing Address:
Contact Person:

COVERAGE & BILLING PERIOD

Coverage Period:
Payment Mode:

MEMBER ID	SUBSCRIBER NAME	COVERAGE TIER	PLAN TYPE	BASE PREMIUM	TOTAL CHARGE

Total Base Premium: _____
Premium Adjustments: _____
Taxes & Admin Fees: _____

Total Amount Due:

PAYMENT INSTRUCTIONS & POLICY TERMS

Please review your active roster details above. Premium payments must reach us by the due date specified on this invoice to prevent disruption or suspension of group coverage. Ensure your Group Policy ID is clearly referenced on all remittance forms.

Bank Name:
Routing Number:
Account Name:
Account Number: