



**SPEC ONLY MEDICAL STOP LOSS
MONTHLY PREMIUM STATEMENT**

Group Name [Redacted]

Policy Effective Date: [Redacted]
Policy Expiration Date: [Redacted]
Report for the Month of: [Redacted]

Policy #: [Redacted]

SPECIFIC PREMIUM CALCULATION

	# OF COVERED INDIVIDUALS **		RATE		MONTHLY COST
Single Employees:	[Redacted]	X	[Redacted]	=	_____
Family Employees:	[Redacted]	X	[Redacted]	=	_____
TOTAL SPECIFIC PREMIUM:					_____

**** Enrollment counts should include COBRA participants and retirees, if applicable ****

ADJUSTMENT EXPLANATION

[Redacted]

TOTAL ADJUSTMENTS: _____

TOTAL GROSS PREMIUM DUE: _____

Monthly Report Produced By: [Redacted]

Date: [Redacted]

**REMITTANCE PAYABLE BY THE 1st OF EACH MONTH
ALL PREMIUM QUESTIONS SHOULD BE DIRECTED TO STAR LINE GROUP AT 1-800-500-4364**

PLEASE MAIL PAYMENT TO:

StarLine Group
180 Teaticket Highway
East Falmouth, MA 02536