



**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]	=	_____
<b>TOTAL SPECIFIC PREMIUM:</b>					_____

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

**ADJUSTMENT EXPLANATION**

[Redacted]

**TOTAL ADJUSTMENTS:** \_\_\_\_\_

**TOTAL GROSS PREMIUM:** \_\_\_\_\_

**SURPLUS LINES TAX %** [Redacted] \_\_\_\_\_

**TOTAL PREMIUM + TAX 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