



**SPEC & AGG 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:					_____

AGGREGATE PREMIUM CALCULATION

Total Employees:	[Redacted]	X	[Redacted]	=	_____
TOTAL AGGREGATE PREMIUM:					_____

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

ADJUSTMENT EXPLANATION

[Redacted]

TOTAL ADJUSTMENTS: [Redacted]

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