UHA
HEALTH INSURANCE

Premium Summary Billing Statement

Group Name: SAMPLE BILL
Mailing Address: 700 BISHOP ST #300
HONOLULU, HI 96813

Statement Date: 11/05/2020
Payment is due by: 12/01/2020
Billing Period: 12/01/2020 to 12/31/2020

Group Number: 012340001

Billing Summary:

Amounts outstanding from the prior month:	$8,060.50
Less: Payments received:	$8,060.50
Adjustments:	$0.00
Other Fees:	$0.00

Total Unpaid amount from prior periods:		$0.00
Total Current Month and Retroactive Charges:	(see detail statement)	$8,897.27
Total Amount Due:		$8,897.27

+ **Important!** For changes in status, such as (1) new subscriber; (2) addition of dependents; (3) deletion of subscribers or dependents, please send Member Enrollment Form or Member Termination Form by mail: UHA Employer Services, 700 Bishop St. Suite 300, Honolulu, HI 96813, email: es@uhahealth.com or fax: (877) 222-3198. Enrollments and changes are effective on the first of the month after our receipt of notice. Enrollments and changes received after the 1st of the month may not be reflected in ths billing.
+ You can also conveniently add or terminate employees and update employee and dependent information online through **UHA's Online Employer Services**. Changes take approximately one business day. To sign up, complete the **Online Employer Access Authorization and Certification Form** (uhahealth.com/uploads/forms/form_online_agreemt.pdf) or contact us for more information.
+ Late payments may result in termination of your policy. Premiums are still due and payable for that period.
+ For questions regarding payments, call Billing at (808) 532-4000, ext 353 from Oahu, or (800) 458-4600, ext. 353 from the neighbor islands.

For information and forms, see our web site **www.uhahealth.com**

Detach here and return bottom portion with your payment

Group Number: 012340001 Payment is due by: 12/01/2020

BILLING STATEMENT

To ensure proper credit to your account, please indicate Group Number on check.

Make check payable to:

UHA
P.O. Box 29590
Honolulu, HI 96820-1990

TOTAL AMOUNT DUE: $8,897.27

AMOUNT ENCLOSED:

EMP_PBC-0078-111120

20201201000254000129590000 8897274

SAMPLE BILL - 3000
Group and Division #:12340001

Benefits: UHA 3000

UHA HEALTH INSURANCE

Premium Invoice

Invoice date: 11/04/2020

Current Billing Period: 12/01/2020 to 12/31/2020

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	A&F Fee	Total
UHA 3000 - 1234000103								
Current Charges								
123000001-01	ASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000002-01	BSINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000003-01	ATWOPARTY, SUBSCRIBER	T	728.22	128.91	10.80	64.77	0.00	932.70
123000004-01	DASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000005-01	EASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000006-01	FASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000007-01	GASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000008-01	HASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
	Subtotal:		3411.11	603.86	48.60	291.71	0.00	4355.28
Retro Adjustments								
123000009-01	ISINGLE, SUBSCRIBER	S	(383.27)	(67.85)	(5.40)	(32.42)	0.00	(488.94)
123000010-01	BTWOPARTY SUBSCRIBER	T	1,542.79	277.42	21.28	129.54	0.00	1,971.03
	Subtotal:		1159.52	209.57	15.88	97.12	0.00	1482.09

UHA 3000 - 123400103 Totals:

7	Single	Medical	$4,570.63	HDS Dental	$388.83
1	Two Party	Drug	$813.43	A&F Fee	$0.00
0	Family	Vision	$64.48		
Summary of Contract Types		**Total Current Month and Retroactive Charges:**			**$5,837.37**

UHA 600 - 1234000106

Current Charges								
123000011-01	AFAMILY SUBSCRIBER	F	1,209.65	206.93	16.20	97.17	0.00	1,529.95
123000012-01	BFAMILY, SUBSCRIBER	F	1,209.65	206.93	16.20	97.17	0.00	1,529.95
	Subtotal:		2419.30	413.86	32.40	194.34	0.00	3059.90

UHA 600 - 1234000106 Totals:

0	Single	Medical	$2,419.30	HDS Dental	$194.34
0	Two Party	Drug	$413.86	A&F Fee	$0.00
2	Family	Vision	$32.40		
Summary of Contract Types		**Total Current Month and Retroactive Charges:**			**$3,059.90**

Current Billing Period Totals:

7	Single	Medical	**$6,989.93**	HDS Dental	**$583.17**
1	Two Party	Drug	**$1,227.29**	A&F Fee	**$0.00**
2	Family	Vision	**$96.88**		
Summary of Contract Types		**Total Current Month and Retroactive Charges:**			**$8,897.27**

PREMIUM BILL RECONCILIATION

Note: Use this section for corrections to the Current Billing Period ONLY

Detail Premium Statement for:

SAMPLE BILL - 600
Group and Division #:12340001

Benefits: UHA 600

UHA HEALTH INSURANCE

Premium Invoice

Invoice date: 11/04/2020

Current Billing Period: 12/01/2020 to 12/31/2020

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	A&F Fee	Total

Terminations:

Employee Name	Member ID #	Termination Date	Amount
			( )
			( )
		Total Subtractions:	( )

Additions: (Completed Enrollment Forms MUST be attached)

Employee Name	Effective Date	Amount
	Total Subtractions:	( )
	Payment Amount Submitted:	

Group Administrator Signature: _____ Date: _____

Important: Changes will not be processed without authorized signature and date