

**STOP LOSS INSURANCE PREMIUM STATEMENT**

**POLICY #:**

**BILLED PERIOD:**

**BILLING DATE:**

**PREMIUM DUE:**

**Attn:**

COVERAGE	TIER	NUMBER OF LIVES		MONTHLY RATE PER TIER	MONTHLY PREMIUM
SPECIFIC STOP LOSS	SINGLE	Previous:			
		Additions +			
		Terminations -			
		Current =			
	FAMILY	Previous:			
		Additions +			
		Terminations -			
		Current =			
AGGREGATE STOP LOSS	COMPOSITE	Previous:			
		Additions +			
		Terminations -			
		Current =			

Return the completed premium statement along with your premium payment to:

**Amalgamated Life Insurance Company**  
P.O. Box 5429  
White Plains, NY 10602-5429

Please retain a copy for your files.

Premium payment is due within 30 days of premium due date.  
**THANK YOU FOR YOUR PAYMENT!**

**TOTAL MONTHLY PREMIUM DUE:**

**ADJUSTMENTS\*:**

**TOTAL MONTHLY PREMIUM REMITTED:**

**\*Adjustment Comments:**