TRIPLE CHOICE PLAN

EXCLUSIVE DENTAL PACKAGES

EXPLANATION OF YOUR PREMIUM STATEMENT

1. Month that your firm is being billed.

2. Firm account number.

3. Date premium is due.

4. Firm name and billing address.

5. Amount billed/received prior month.

6. Four digit employee identification number.

7. The name section shows the name of the insured employee and any activity that might occur in the current month's statement.

8. Coverage codes:

   E = Employee
   C = Employee + Dependent Child(ren)
   S = Employee + Dependent Spouse
   F = Employee + Family

9. This section shows premium due for any of the specified plans.

10. Total premium for all coverage(s) on each employee and dependent, if applicable.

11. This message reflects addition of employee with effective date and retroactive adjustment.

12. Employee terminated with effective date and retroactive adjustment.

13. Coverage code change with retroactive adjustment.

14. Shows number of employees and the premium per employee for optional fiduciary responsibility errors and omissions coverage required under Title I of ERISA.

15. Total amount of premium for all the coverage your employees have.

16. Address where premium payment and statement should be remitted.

17. Balance from previous bill.

18. Credits/debits for added or terminated employees.

19. Any type of credit or debit that have been manually added to your statement.

20. Over/under premium received over or under the amount billed.

21. Administration/firm fees: charges for administering account.

22. Install fees - fee to add new employees. Does not apply to Triple Choice Plan.

23. Total current premium firm owes including any charges/credits that may have occurred in items 17-22.

24. This section should be used for any changes or deletion of employee coverage:

    A. Check the appropriate box for change or delete.
    B. Print social security number.
    C. Print last name.
    D. Check boxes of plan affected.
    E. Check if changing dependent status.
    F. List effective date of change.
    G. List new name, salary or life volume.

PREMIUM STATEMENT

KELSEY NATIONAL CORPORATION
3030 SOUTH BUNDY DRIVE
LOS ANGELES, CA. 90066
(310) 390-1000 • (800) 366-5656 • FAX (310) 391-6534

Triple Choice Plan

COVERAGE MONTH	ACCOUNT NUMBER
1 05/01/1999	2 920001

3 DUE DATE: 15th OF MONTH PRIOR TO COVERAGE MONTH.

4
MAIYA THOMAS
THE COMPANY
1200 N. MAIN STREET
ANYTOWN, CA 00009-5670

5
1. AMOUNT BILLED LAST PERIOD
2. AMOUNT RECEIVED, THANK YOU

COVERAGE CODES
E = EMPLOYEE
C = EMPLOYEE/CHILD
S = EMPLOYEE/SPOUSE
F = FAMILY

CONFIDENTIAL

PLEASE RETURN THE ENTIRE REMITTANCE COPY WITH YOUR CHECK

6 CERT. NO.	7 NAME	8 COV CODE	9 DENTAL VISION	LTD PREMIUM	LTD VOLUME	STD PREMIUM	STD BENEFIT	COV CODE	LIFE PREMIUM	LIFE VOLUME	AD&D PREMIUM	10 TOTAL PREMIUM
0000												
1234	DAVIS, HENRIETTA	C	16.50									16.50
11 ADDITION EFFECTIVE	04/01/1999		16.50									16.50
7298	JOHNSON, SHARON	E	26.93									26.93
8797	JONES, SHEILA											
12 TERMINATED EFFECTIVE	04/01/1999		26.93-									26.93-
6653	LEWIS, CHARLES	S	51.17									51.17
5582	MCCOY, LOUIS	S	51.17									51.17
13 COVERAGE CODE CHANGE	04/01/1999		25.59-									25.59-
0903	THOMAS, MAIYA											
PRODUCT EFECTIVE	04/01/1999		28.29									28.29

14 FIDUCIARY COVERAGE (	0 @ $2.15)			
15 TOTAL CURRENT PERIOD PREMIUM				145.77
17 BALANCE FORWARD		18 ADJUSTMENTS	7.73-	7.73-
19 MANUAL ADJUSTMENTS		20 OVER/UNDER		
21 FIRM/ADMIN. FEES	22.00	22 INSTALL FEES		22.00
		23 TOTAL DUE		160.04

PLEASE MAKE CHECK PAYABLE TO:
16 AMERICHOICE
REMITTANCE ADDRESS:
DEPARTMENT LA 22073
PASADENA CA 91185-2073

REPORT EMPLOYEE CHANGES HERE

CHANGE	DELETE	SS#	LAST NAME	ALL PLANS	DENTAL	VISION	LTD	STD	LIFE	AD&D	COV CODE CHANGES FROM	COV CODE CHANGES TO	EFFECTIVE DATE OF CHANGE	NEW NAME, SALARY, OR LIFE VOLUME
24														

PLEASE SEE BACK OF STATEMENT FOR IMPORTANT INSTRUCTIONS