



P.O. Box 100102
Columbia, SC 29202-3102

GROUP INSURANCE SELF BILLED PREMIUM REPORT
MAIL TO: COMPANION LIFE INSURANCE COMPANY • P.O. BOX 100102 • COLUMBIA, S.C. 29202-3102

DATE _____

GROUP NAME _____

GROUP NO. _____ DUE DATE _____

Type of Coverage	Number of Lives Currently Insured	Number of Additions	Number of Deletes	Prior Month's Volume	Volume Increases (Plus) This Month	Volume Decreases (Minus) This Month	Ending Volume This Month	Rate (Ending Volume X Rate)	Amount

IMPORTANT: PLEASE PROVIDE THE FOLLOWING INFORMATION ON EACH INSURED WHOSE BASIC AND/OR SUPPLEMENTAL COVERAGE EXCEEDS \$100,000.

Action (Add/Del)	Effective Date	Name	Date of Birth	Sex	Social Security #	Insured Volume			

Pay this amount: _____

Signed _____

Title _____