

PREMIUM PAYMENT PROCEDURES

Premium payments sent by regular mail should be made payable to Summit Reinsurance Services, Inc. and sent to the address below. We have revised the premium statements to be submitted for each due month; a sample is enclosed for your reference.

**Summit Reinsurance Services, Inc.
7030 Pointe Inverness Way, Suite 350
Fort Wayne, IN 46804-1564**

Payments can be made by electronic funds transfer (EFT) if you so desire. Please contact Summit Reinsurance Services, Inc. for instructions to establish the EFT.

The HMO reinsurance contracts provides a grace period of 31 days following the premium due date. The contract will remain in force during the grace period. Failure to pay any month's premium within 31 days after the premium due date will result in the termination of the contract as of the premium due date.

If you have any questions concerning your premium payments, please feel free to contact Steve Wolfer at 260-469-3016 or Gail Amstutz at 260-407-3973.

Summit Reinsurance Services, Inc.

7030 Pointe Inverness Way, Suite 350 / Fort Wayne, IN 46804
(260) 469-3000 / Facsimile: (260) 469-3014

HMO PREMIUM REMITTANCE FORM

Reinsured: _____ Agreement Number: _____
 Agreement Period: _____ Premium Month: _____

Please send premium remittance by regular mail or overnight mail to:
SUMMIT REINSURANCE SERVICES, INC.
7030 Pointe Inverness Way, Suite 350
Fort Wayne, IN 46804

Please write the applicable policy number(s) on check.

MONTHLY PREMIUM CALCULATION:					
	Number of Members		Rate Per Member	=	Premium
Commercial	_____	X	_____	=	\$ _____
Commercial POS	_____	X	_____	=	\$ _____
Medicare	_____	X	_____	=	\$ _____
Medicaid AFDC	_____	X	_____	=	\$ _____
Medicaid Healthy Beginning	_____	X	_____	=	\$ _____
Medicaid SSI w/Medicare	_____	X	_____	=	\$ _____
Medicaid SSI w/o Medicare	_____	X	_____	=	\$ _____
Total Current Enrollment:	_____				Total Premium Current Month: \$ _____

ADJUSTMENT FOR THE MONTH OF:					
	Members Previously Reported:	Actual Member Count:	Adjustment to Count:	x Premium Rate:	= Premium Adjustment:
Commercial					
Commercial POS					
Medicare					
Medicaid AFDC					
Medicaid Healthy Beginning					
Medicaid SSI w/Medicare					
Medicaid SSI w/o Medicare					
Total Adjustment to Current Month's Premium:					
Total Current Month Premium Plus/(Minus) Adjustment = Net Due Summit Re:					

Completed by: _____ Date: ____ / ____ / ____
Name Title

Company: _____ Telephone: (____) ____ - ____
 Address: _____ Facsimile: (____) ____ - ____