Harvard Pilgrim Health Care

Premium Deposit Statement

Group Name: _____

Effective Date: _____

Plan 1	**Plan Selected:** _____	Check # _____

	Premium Rate $	**Subscriber #**	**Total**
Individual	_____ X	_____ =	_____
EE/SP	_____ X	_____ =	_____
EE/Ch(ren)	_____ X	_____ =	_____
Family	_____ X	_____ =	_____
		Total Deposit	$_____

Plan 2 (*if applicable*)	**Plan Selected:** _____	Check # _____

	Premium Rate $	**Subscriber #**	**Total**
Individual	_____ X	_____ =	_____
EE/SP	_____ X	_____ =	_____
EE/Ch(ren)	_____ X	_____ =	_____
Family	_____ X	_____ =	_____
		Total Deposit	$_____

Employer Signature: _____   Date: _____

Title: _____

For Harvard Pilgrim Health Care Use Only
Group/Division Number:
Plan 1: _____/_____
Plan 2: _____/_____

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care,
Harvard Pilgrim Health Care of New England and HPHC Insurance Company.