



Billing Statement

Group/Subgroup: 1000000 0001

601 SW Second Ave
Portland, OR 97204-3156
503-228-6554

Billing Date	For Coverage Beginning
07/07/2007	08/01/2007

Class: 0001 Description: Company Name

Subscriber ID #	Subscriber SSN	Employee Name	Coverage Date	Medical				Total
A11111111	999999999	Adams, John	08/01/2007	\$120.00				\$120.00
B22222222	888888888	Brown, Greg	08/01/2007	\$120.00				\$120.00
C33333333	777777777	Gore, Geena	08/01/2007	\$120.00				\$120.00
D44444444	666666666	Jones, Alison	08/01/2007	\$120.00				\$120.00

Total for Class 0001: \$480.00

Class: 0002 Description: Company Name

Subscriber ID #	Subscriber SSN	Employee Name	Coverage Date	Medical				Total
E55555555	444444444	Aries, Bob	08/01/2007	\$120.00				\$100.00
F66666666	333333333	Camps, Joe	08/01/2007	\$120.00				\$100.00
G77777777	222222222	Hunt, John	08/01/2007	\$120.00				\$100.00
H88888888	111111111	Young, Sally	08/01/2007	\$120.00				\$100.00

Total for Class 0002: \$400.00

Company Name
Company Name
Company Address
City, State, Zip

Invoice Number: 555555555



Billing Statement Totals

Group/Subgroup: 10000000 0001

601 SW Second Ave
Portland, OR 97204-3156
503-228-6554

Billing Date	For Coverage Beginning
07/07/2007	08/01/2007

Group Billing Totals

Benefit Type	Subscriber Count	Subscriber Premium	Dependent Count	Dependent Premium		
Medical Dental Vision Pharmacy	8	\$880.00			Total this bill	\$880.00
					Outstanding Balance	\$0.00
					As of 07/07/2007	
					Due Date:	08/01/2007
					Please Pay This Amount	\$880.00

Company Name
Company Name
Company Address
City, State, Zip

Invoice Number: 555555555

ODS Billing Summary

10000000
 Due Date: 08/01/2007 Bill Date: 07/07/2007 Month of Coverage: 08/01/2007

Bill Summary							Adjustment Worksheet (Complete only if making adjusted payment – not if paying in full)				
Group	Subgroup	Current Month Amount	Retroactive Amount	Subgroup Total	Outstanding From Prior Month	Total Due	Adjustments for Adds (+)	Adjustments for Terms (-)	Adjustments for Transfers-Out (-)	Adjustments Transfers-In (+)	Adjusted Total (Total due +/- Adjustments)
10000000	0001	\$880.00	\$0.00	\$880.00	\$0.00	\$880.00					

Please retain this copy for your records.

Company Name
 Company Name
 Company Address
 City, State, Zip

Invoice Number: 555555555



ODS Billing Summary

10000000
 Due Date: 08/01/2007 Bill Date: 07/07/2007 Month of Coverage: 08/01/2007

Bill Summary							Adjustment Worksheet (Complete only if making adjusted payment – not if paying in full)				
Group	Subgroup	Current Month Amount	Retroactive Amount	Subgroup Total	Outstanding From Prior Month	Total Due	Adjustments for Adds (+)	Adjustments for Terms (-)	Adjustments for Transfers-Out (-)	Adjustments Transfers-In (+)	Adjusted Total (Total due +/- Adjustments)
10000000	0001	\$880.00	\$0.00	\$880.00	\$0.00	\$880.00					

**Please return this summary with your payment in the enclosed envelope.
 Please make checks payable to: ODS**

Company Name
 Company Name
 Company Address
 City, State, Zip

Invoice Number: 555555555

Group ID: 10000000 **Group Name:** _____ **Subgroup ID:** _____ **Subgroup Name:** _____

Billing Change Form for Month of _____

Adds (New enrollments, dependent adds, and adding coverage) – Applications Required for Adds

Subgroup	Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
				Total for Adds	\$	\$

Terms (Termination of subscribers, dependents, or coverage)

Subgroup	Termination Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
				Total for Terminations	\$	\$

Changes (Changes in eligibility, benefits, or subgroup)

Subgroup	Change Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
				Total for Changes	\$	\$

Instructions: Please total changes by subgroup and transfer the amounts to the ODS Billing Summary form.
 Return Billing Change Forms and the ODS Billing Summary form with your payment.
 If you have more changes than this form can accommodate, please copy this form.