

At Paramount, we continually strive to improve our service to you, our valued customer.

A brief explanation of our statement is shown on the reverse side of this brochure.

# QUESTIONS?

Paramount  
Billing Department is available  
to answer your questions

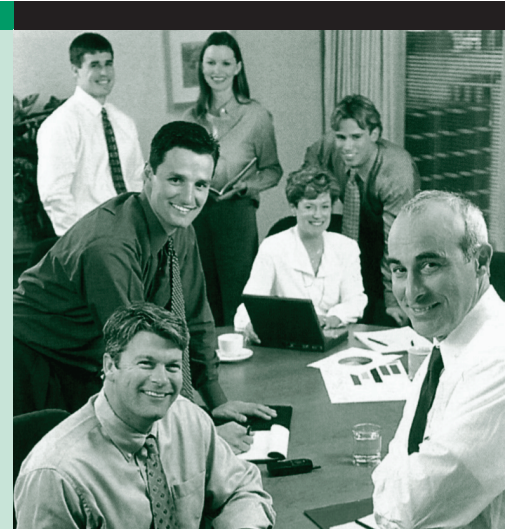
Monday through Friday  
8:00 a.m. - 4:30 p.m.

at  
419-887-2585



82739

## Understanding Our Statement



# Keys To Understanding Your Paramount Statement

NUMBERED AREAS POINT OUT WHERE IMPORTANT INFORMATION CAN BE FOUND ON OUR STATEMENT.

## STATEMENT EXPLANATIONS

- 1 Area to fill out if paying by credit card
- 2 Date statement was created
- 3 Payment due date
- 4 Group division #
- 5 Invoice #
- 6 Current balance or total due
- 7 Area to write amount being paid at this time
- 8 Name and address of person recorded as being responsible for account
- 9 Remit to address
- 10 Description of total number of contracts and members billed for the stated bill period
- 11 Billing summary that includes previous balance, adjustments, payments, current premiums & total amount due as of the invoice date.
- 12 Web site address, important phone numbers, and other important information

DIVISION# WHH1200000

### BILLINGS

10	TOTAL CONTRACTS	3
11	TOTAL MEMBERS	14
-----		
	PREVIOUS BALANCE	\$2,350.20
	PAYMENTS	\$2,350.20-
-----		
	BALANCE FORWARD	\$0.00
	MISC CHARGES	\$0.00
	ADJUSTMENTS	\$0.00
	CURRENT PREMIUMS	\$2,959.65
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	<b>**YOUR CURRENT BALANCE IS</b>	<b>\$2,959.65**</b>
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### SUMMARY OF BILLINGS

CONT	BENEFIT			AMOUNT
TYPE	PACKAGE	COUNT		
-----				
5F	8U	1		\$2,959.65
PREMIUM TOTAL:				\$2,959.65
ADJUSTMENT TOTAL:				\$0.00

Note: Please use application and termination forms to add or delete a member. If forms are needed, please visit our website or call the Marketing Department. [www.paramounthealthcare.com](http://www.paramounthealthcare.com)

12

Billing: 419-887-2585

Click on the employer/broker information and materials request.  
Marketing: 419-887-2863

Membership: 419-887-2536

Fax: 419-887-2016

\* PLEASE RETAIN FOR YOUR RECORDS

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT 653057

3A301KA3V:1.2



PARAMOUNT HEALTH CARE  
1901 INDIANWOOD CIRCLE  
MAUMEE, OH 43537

30522-U609

RETURN SERVICE REQUESTED

PAGE: 1 OF 1



0202

Check here if a change of address is indicated on the back of this form

8  
VALUED CUSTOMER  
123 N. MAIN STREET  
ANYTOWN, USA 12345-6789

CHECK WHICH CARD YOU ARE USING AND FILL OUT BELOW.			
1	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> VISA	
	CARD NUMBER	SIGNATURE CODE	
	SIGNATURE	EXP. DATE	
4	CORP # / GROUP# / DIVISION #	INVOICE #	5
	WHH1200000	PC4000001234	
2	STATEMENT DATE	PAYMENT DUE ON / BEFORE	3
	00/00/00	00/00/00	
6	PLEASE PAY THIS AMOUNT	TOTAL AMOUNT PAID	7
	\$2,959.65		

30522-U608\*TA301JM8M000001

9  
PARAMOUNT HEALTH CARE  
P.O. BOX 76656  
CLEVELAND, OH 44101-6500

WHH11000002011080120110831002959656

For answers to questions regarding your balance or payment, please call the Billing Department.

Department. The individual department numbers are listed on the bottom of the statement.

For answers to questions regarding member or contract numbers, or questions about additions or terminations, please call the Membership Department. For information regarding individual rates please call the Marketing

Please keep a copy of the original statement in a safe place, as future statements may not include the details of the original.