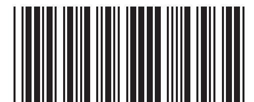
At Paramount, we continually strive to improve our service to you, our valued customer.

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



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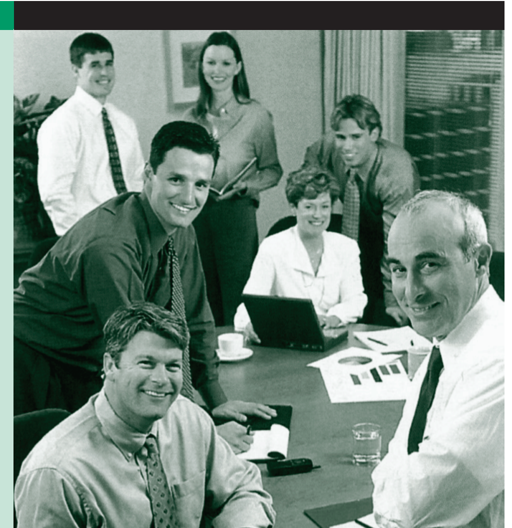
Understanding Our Statement



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

TOTAL CONTRACTS	3
(10) TOTAL MEMBERS	14
(11)	
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
**YOUR CURRENT BALANCE IS	$2,959.65**

SUMMARY OF BILLINGS

CONT TYPE	BENEFIT PACKAGE	COUNT	AMOUNT
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.
(12) www.paramounthealthcare.com
Click on the employer/broker information and materials request.

Billing: 419-887-2585 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

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

0202

(1) CHECK WHICH CARD YOU ARE USING AND FILL OUT BELOW.

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

(4) CORP # / GROUP# / DIVISION #		INVOICE # (5)
WHH1200000		PC4000001234
(2) STATEMENT DATE	PAYMENT DUE ON / BEFORE	(3) BILL PERIOD
00/00/00	00/00/00	00/00/00 - 00/00/00
(6) PLEASE PAY THIS AMOUNT		TOTAL AMOUNT PAID (7)
$2,959.65		

30522-U608*TA301JM8M000001

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

(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.

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

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