

9/06/24
SCANNED

Manage your Account:
www.uhceservices.com

Invoice No: 835399970638
Invoice Date: 09/06/2024
Consolidated Customer No: 9742999921
Customer Numbers: 1351166;09S0588
Coverage Period: 10/01/2024 - 10/31/2024
Due Date: 10/01/2024



253IMBSTANDARDBW0008002-06406-01

VERATEX
CLAUDE SIMON
PO BOX 682
NEW YORK NY 10108-0682



Account Summary

Previous Balance	\$8,745.81
Payments (-)	-\$4,338.57
Account Adjustments (+/-)	\$0.00
Current Charges (+)	\$4,346.20
 Total Balance Due	 \$8,753.44

Thank you for your business.

About Your Payment

We offer several payment options to help you manage your account.

Pay Online. Go to www.uhceservices.com to make a one-time payment or schedule monthly payments directly from your bank account.

Pay By Phone. Call **1-866-764-7736**, TTY 711, 24 hours a day, 7 days a week, to make a payment directly from your bank account. Please reference your customer number 1351166 and bill group number 263066 when prompted.

Pay By Check. Send a check to the address listed below. Checks returned for lack of funds or checks that can't be cashed for any reason are not considered payment.

Payment is due in full on or before the due date above. If full payment is not received by the end of your grace period, your coverage may be terminated as stated in your policy requirements. If a premium payment is deposited late, it does not automatically mean we will accept the premium.

This invoice combines the information from both of your customer billing account details.

Please detach and return with your payment.

Customer Name	Customer Number	Payment Due Date	Invoice #
VERATEX	9742999921	10/01/2024	835399970638

Send payment to:

UHS Premium Billing
PO BOX 94017
Palatine, IL 60094-4017

Amount due: \$8,753.44

Amount Enclosed

\$												
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9/28/24
SCANNED



Expanding digital solutions – choose paperless invoicing

We appreciate this opportunity to help streamline administrative efficiencies and reduce paper mailings. Our records show that you are still receiving a paper invoice from us. Did you know that you can view your monthly invoice online and further reduce the amount of paper mail that you receive and handle?

Advantages of using the benefits administration website

In addition to being a resource for your specific plan information and covered employee population, uhceservices.com offers easy access to your premium invoices and payments. In the Billing and Payment Center of the website, you can:

- View invoices, payments, balances and statements
- Request “Bill vs. Paid” report
- Manage banking information

To go paperless and turn off delivery of your monthly premium invoice by U.S. Mail, please call the customer service phone number on this invoice to have **Electronic Invoice Delivery Only** selected.

Not registered yet?

Visit us at uhceservices.com and register using your Customer ID.

Once registered, you can:

- Sign up for paperless billing
- View, manage and pay your bill
- Make eligibility changes
- Request health plan ID cards and more

Easy access to your
invoices and payments

- Sign in to uhceservices.com to view or print your company’s monthly premium invoice
- For help signing in or registering on the website, call **1-866-908-5940**, TTY **711**, 8 a.m. to 8 p.m. ET, Monday – Friday

9/20/24
SCANNED

Invoice No: 350199284637
 Invoice Date: 09/06/2024
 Bill Group: 263066
 Coverage Period: 10/01/2024 - 10/31/2024
 Due Date: 10/01/2024



Summary

Description	Employee Count	Total Volume (000's)	Net Amount
312068-ALL ELIGIBLE EMPLOYEES			
NY P FRDM NG 20/40/100 PPO 24			
Employee	1		\$1,512.84
Employee & Child(ren)	1		\$2,571.83
Subtotal, NY P FRDM NG 20/40/100 PPO 24	2		\$4,084.67
Subtotal 312068-ALL ELIGIBLE EMPLOYEES			\$4,084.67
Adjustments			
Account Adjustments			\$0.00
Current Adjustments			\$0.00
Subtotal, Adjustments			\$0.00
Subtotal Plan Charges			\$4,084.67

Questions? We're here to help.



Toll free 1-866-764-7736



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9/20/24
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Invoice No: 426619527965

Invoice Date: 09/06/2024

Bill Group: 1

Coverage Period: 10/01/2024 - 10/31/2024

Due Date: 10/01/2024



Summary

Description	Employee Count	Total Volume (000's)	Net Amount
09S0588-VERATEX INC.			
Dental VPPO			
Employee	2		\$130.16
Employee & Child(ren)	1		\$131.37
Subtotal, Dental VPPO	3		\$261.53
Subtotal 09S0588-VERATEX INC.			\$261.53
Adjustments			
Account Adjustments			\$0.00
Current Adjustments			\$0.00
Subtotal, Adjustments			\$0.00
Subtotal Plan Charges			\$261.53
Grand Total			\$4,346.20

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9/20/24
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Invoice No: 350199284637

Invoice Date: 09/06/2024

Bill Group: 263066

Coverage Period: 10/01/2024 - 10/31/2024

Due Date: 10/01/2024

Details

Current Detail - 10/01-10/31/2024								Adjustment Detail			Totals
Policy No.	Name	Plan	ID	Coverage	Status	Vol (000's)	Charge Amount	Period	Code	Amount	Total
312068	D'alessio, Claudio	NY P FRDM NG 20/40/100 PPO 24	*****505900	E	A		\$1,512.84				\$1,512.84
312068	Simon, Carolyn	NY P FRDM NG 20/40/100 PPO 24	*****765600	EC	A		\$2,571.83				\$2,571.83
Subtotal Plan Charges								\$4,084.67			\$0.00
											\$4,084.67

Coverage Type

E	Employee Only
ES	Employee and Spouse
ESC	Employee and Family
EC	Employee and Child(ren)
E1D	Employee and One Dependent
E2D	Employee and Two Dependents

E3D	Employee and Three Dependents
E5D	Employee & One or More Dependent
E6D	Employee & Two or More Dependents
E7D	Employee & Three or More Dependents
E8D	Employee & Four or More Dependents
E9D	Employee & Five or More Dependents

Status

A	Active
C	Cobra
P	Pre 65 Retiree
R	Post 65 Retiree
S	Surviving Insured

Code

ADD	Retroactive Addition
TRM	Retroactive Termination
CHG	Retroactive Change

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Consolidated Customer No: 9742999921

VERATEX INC.

Customer No: 09S0588

9/20/24
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Invoice No: 426619527965

Invoice Date: 09/06/2024

Bill Group: 1

Coverage Period: 10/01/2024 - 10/31/2024

Due Date: 10/01/2024

Details

Current Detail - 10/01-10/31/2024								Adjustment Detail			Totals
Policy No.	Name	Plan	ID	Coverage	Status	Vol (000's)	Charge Amount	Period	Code	Amount	Total
09S0588	DALESSIO, CLAUDIO	Dental VPPO	*****8501	E	A		\$65.08				\$65.08
09S0588	SIMON, CAROLYN	Dental VPPO	*****1470	EC	A		\$131.37				\$131.37
09S0588	SIMON, CLAUDE	Dental VPPO	*****6339	E	A		\$65.08				\$65.08
Subtotal Plan Charges								\$261.53	\$0.00		\$261.53
Grand Total									\$0.00		\$4,346.20

Coverage Type	Status	Code
E Employee Only	A Active	ADD Retroactive Addition
ES Employee and Spouse	C Cobra	TRM Retroactive Termination
ESC Employee and Family	R Retiree	CHG Retroactive Change
EC Employee and Child(ren)	T Terminated	

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Invoice No: 835399970638
Invoice Date: 09/06/2024
Consolidated Customer No: 9742999921
Coverage Period: 10/01/2024 - 10/31/2024
Due Date: 10/01/2024



About Your Bill

Employee and dependent information contained on this invoice is based on the most current information provided by you in your capacity as Plan Administrator to Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company of New York.

Payment is due in full on or before 10/01/2024. If full payment is not received by the end of your grace period, your coverage may be terminated as stated in your policy requirements. For more information about grace periods, please see your plan documents (for example: Group Policy).

Your payment can take up to 10 days to post to your account. If we receive it after the Invoice Date, you'll see it in your next bill.

Eligibility Changes

Please be advised that we are not able to process eligibility changes sent with your payment.

See your plan documents for more information on how to make any policy, employee, and dependent changes.

Questions about your bill?

If you have any questions, please call us toll-free at 1-866-764-7736, TTY 711, 8 a.m. - 8 p.m. ET, Monday – Friday. Please have your billing customer number and bill group number available when you call.

Underwritten by Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company of New York

Questions? We're here to help



Toll free 1-866-764-7736



www.uhcservices.com

2024
SCANNED

Customer invoice basics

How to read the invoice summary page

You may notice the invoice has a new format. Here's an example, for illustrative purposes, of the new invoice summary page.

1 Manage your account

Invoice number: Number for each invoice

Invoice date: Date the invoice is created

Customer number: Number we gave to the account

Bill group number: This number is based on the billing address. There will only be one bill group number

Coverage period: Dates being paid for

Due date: This is the date the payment is due, which is subject to the grace period in the Group Enrollment Agreement and Group Policy or Administrative Services Agreement, as applicable

2 Account summary

Previous balance: Total due on the last invoice

Payments: Amount paid since the last invoice

Account and current adjustments: Find more information about adjustments made to the account on the Details page of the invoice

Current charges: New amounts owed since the last invoice

Total balance due: Amount owed

3 About your payment

Choose the payment option that works best for you

4 Send payments to this address

If paying by check, always mail your payment to the address shown on your bill

continued

Manage your Account			
Invoice No. 88111111 Bill Date 09/01/2021 Customer No. 1234567 Bill Group No. 8811111 Coverage Period 09/01/2021 – 09/30/2021 Due Date 09/15/2021			
1 Thank you for your business.			
2 About Your Payment We offer several payment options to help you manage your account.			
3 Pay Online: Go to www.unitedhealthcare.com to make a one-time payment or schedule monthly payments directly from your bank account.			
4 Pay By Phone: Call 1-866-764-7736, TTY 711, 24 hours a day, 7 days a week, to make a payment directly from your bank account.			
5 Pay By Check: Use the enclosed envelope to send us your payment. Your payment must be sent to the address on the form below to make sure it is applied to your account. Checks returned for lack of funds or checks that can't be cashed for any reason are not considered payment.			
Payment is due in full on or before the due date above. If full payment is not received by the end of your grace period, your coverage may be terminated as stated in your policy requirements. If a premium payment is deposited late, it does not automatically mean we will accept the premium.			
Please detach and return with your payment.			
Customer Name ABC Company		Customer Number 1234567	Payment Due Date 09/15/2021
Send payment to: 4 UnitedHealthcare Premium Billing PO BOX 94017 Prairie, IL 60069-4017 		5 Amount Due: \$8,000.00 6 Amount Enclosed: <input type="text"/>	
87992601520010000000A54398711254206154			

