CM REGENT SOLUTIONS®
SHORT TERM DISABILITY INSURANCE PREMIUM STATEMENT

MAIL PAYMENT TO:

CM Regent, LLC
P. O. Box 4725
Lancaster, PA 17604

Policy #: _____

School District: _____

Premium Period: _____
Month Year

SHORT TERM DISABILITY INSURANCE

	Number of Lives					
Classifications	Last Month	Add or Subtract	Total in Force	Total Weekly Insured Payroll	Billing Rate	Monthly Premium
				$	.___per $10 of Benefit	$
				$	.___per $10 of Benefit	$
				$	.___per $10 of Benefit	$
Adjustments (Attach letter or include with totals above)				$	.___per $10 of Benefit	$
Grand Totals			#	$		
				Total Premium Due		**$**

_____
Prepared by Date

_____
Email Address

_____
Phone Number (including extension)

PLEASE ENTER YOUR PAYMENT INFORMATION BELOW

Check #: _____

Date: _____

Amount: _____

PLEASE NOTE THE FOLLOWING INSTRUCTIONS

- Statements are due no later than the **first** of the covered month.
- Make your payment payable to ***CM Regent, LLC***.
- Attach a letter of explanation for all adjustments.
- Keep a copy of the statement for your records.
- Call Tyffanie Kirkpatrick at 1-866-403-7700 extension 2318 or email us at ebss@cmregent.com

(School ID)