

## CM REGENT SOLUTIONS®

### LONG 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

### LONG TERM DISABILITY INSURANCE- Voluntary

Classifications	Number of Lives			Total Monthly Insured Payroll	Billing Rate	Monthly Premium
	Last Month	Add or Subtract	Total in Force			
				\$	___ per \$100 of Payroll	\$
				\$	___ per \$100 of Payroll	\$
				\$	___ per \$100 of Payroll	\$
				\$	___ per \$100 of Payroll	\$
Adjustments (Attach letter or include with totals above)					___ per \$100 of Payroll	\$
<b>Grand Totals</b>			#	\$		
					<b>Total Premium Due</b>	<b>\$</b>
Prepared by _____ Date _____				<b>PLEASE ENTER YOUR PAYMENT INFORMATION BELOW</b>		
Email Address _____				Check #: _____		
Phone Number (including extension) _____				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](mailto:ebss@cmregent.com)