

UnitedHealthcare
Dept. CH 10151
600550151C0009
Palatine IL 60055-0151



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1356473PBA0150201

DANA POINT CONDO ASSN
LISETTE RAY
1519 E CENTRAL ROAD
ARLINGTON HEIGHTS IL 60005

Invoice No: 0031439615
Invoice Date: May 15, 2013
Customer No: 608776
Bill Group: 1
Coverage Pd: 06/01-06/30/2013
Due Date: Jun 01, 2013

Account Summary

Previous Balance	\$1,140.34
Payments (-)	\$-1,140.34
Bill Group Adjustments (+/-)	\$0.00
Late Payment Charge (+)	\$0.00
Current Charges (+)	\$1,140.34
Current Adjustments (+/-)	\$0.00
Total Balance Due	\$1,140.34

Invoice Summary

Description	Employee Count	Total Volume (000's)	Rate	Net Amount
06P1315-DANA POINT CONDO ASSN				
UHC Core				
EMPLOYEE	2		\$0.00	\$1,140.34
Subtotal - 06P1315-DANA POINT CONDO ASSN	2		\$0.00	\$1,140.34
Prop # 0554				
Desc. Employee Insurance				
AMT to be Paid 1140.34				
Acct # 7086				
Manager's Initials				
Date Appeared 5/20/13				
Special Instructions				
TOTAL	2		\$0.00	\$1,140.34

Please Detach and Return the Portion Below with Remittance

Customer Name	Customer Number	Payment Due Date	INV #
DANA POINT CONDO ASSN	608776	Jun 01, 2013	0031439615

Return payment stub to:

UnitedHealthcare Insurance Company
Dept. CH 10151
Palatine IL 60055-0151



AMOUNT DUE

\$1,140.34

AMOUNT PAID

\$

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Invoice Detail

Policy No.	Name Plan	ID	Coverage	Volume(000's)	Charge Amount
06P1315	MEDINA, JUAN UHC Core	XXXXXX7617-00	E		\$347.39
06P1315	MULVEY, STEVEN A UHC Core	XXXXXX2459-00	E		\$792.95
TOTAL					\$1,140.34

PLEASE VISIT EMPLOYER ESERVICES AT WWW.EMPLOYERESERVICES.COM TO perform real-time eligibility transactions, view and pay your invoices, request ID cards and more!

Employee and dependent information contained in this report is based on the most current information provided by the Employer, acting as Plan Sponsor and/or Plan Administrator (the organization which established the employee welfare plan for its employees) to the Company (a division of UnitedHealth Group contractually administering claims on behalf of the Employer). Changes to employees and dependent information are the responsibility of the Employer, acting as Plan Sponsor and/or Plan Administrator, and must be submitted to the Company on a timely basis. Please do not submit employee changes by noting them on this invoice. This address is used for payment purposes only and written instructions sent to this address will not be processed.

To keep your group insurance coverage in effect, it is important that we receive full payment of all amounts due, as required by your Group Contract/Policy. If your Group Contract/Policy requires an initial advance notice of termination for non-payment of premium, this statement will serve as the required initial advance notice of termination that will be effective in accordance with your Group Contract/Policy.

Balance reflected is as of the invoice date and may be subject to change pending verification of payment or direct debit bank processing. Any changes will be reflected on your next invoice.

Applicable to Employers with Enrollees residing in Texas: Employers are responsible for premiums on Enrollees who are no longer eligible for group coverage until the end of the month in which you notify UnitedHealthcare of the Enrollee's termination. UnitedHealthcare's preferred method for notification of termination of coverage is through Employer eServices at www.employereservices.com.

Please contact your Billing/Accounts Receivable Representative if you have any questions. Thank you. 1-888-842-4571

This invoice covers eligibility charges from the following entities:
 UnitedHealthcare Insurance Company of Illinois

The amounts listed on this invoice are based, in part, on the age and/or gender of each covered employee and spouse (where applicable), and are provided solely for internal billing purposes. You are solely responsible for establishing the contribution practices for your employees. Federal, State, and local laws may prohibit you from charging different contribution amounts based on an employee's gender or other protected class status.