RBS Re
An HM Insurance Group Company

Forward to: **RBS Re**
7301 S.W. 57th Ct.
Suite 450
South Miami, FL 33143
Attn: Accounting Dept.
Tel: (305) 262-2662
Fax: (305) 262-9909
premium@rbsre.com

EMPLOYER STOP-LOSS PREMIUM TRANSMITTAL FORM

Employer: _____ Policy #: _____ Administrator: _____

Calculation for the Current Month/Year: _____ **, 20** _____

Type: Single; Family; Composite, etc.				
Number Covered:				
Spec Premium Rate:	$	$	$	$
Spec Premium:	$	$	$	$
Agg Premium Rate:	$	$	$	$
Agg Premium:	$	$	$	$
Total Premium:	$	$	$	$
Commission Percentage:	%	%	%	%
Total Commission:	$	$	$	$

Adjustment for previous month of _____ **, 20** _____

Type:				
Number Covered:				
Previously Reported Covered:				
Membership Adjustment:				
Spec Premium Rate:		$	$	$
Spec Premium Adjustment:	$	$	$	$
Agg Premium Rate:	$	$	$	$
Agg Premium Adjustment:	$	$	$	$
Total Premium Adjustment:	$	$	$	$
Commission Percentage:	%	%	%	%
Total Commission Adjustment:	$	$	$	$

Total Amount of Premium Check: $ _____ Check #: _____

Submitted by: _____ Title: _____ Date: _____

Address: _____ Tel #: _____ Fax #: _____