EMPLOYEES BENEFITS COUNCIL
120 N. Robinson, Suite 1100
Oklahoma City, Oklahoma 73102
405-232-1190 or 1-800-219-8115

EMPLOYEE PREMIUM REMITTANCE REQUEST

Date received by EBC Accounting: _____

Name _____ SSN _____

Agency Name _____ Agency#/Loc _____

Period & specific reason for remittance:

_____

	Name of Carrier	Enrolled Premium Amount	Premium Amount Paid	Premium Amount Due	Premium due by Employee	Premium due by Agency
Health						
Dental						
Life						
Supp Life						
Dep Life						
Disability						
Vision						
Spending Account						

Total Remittance Due per Period: $ _____ $ _____ $ _____

Total Remittance: for _____ period(s) x $ _____ = $ _____

Total Employee Remittance: for _____ period(s) x $ _____ = $ _____

Total Agency Remittance: for _____ period(s) x $ _____ = $ _____

Mail Remittance by the 10th of each month to:

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