ADMINISTRATION EXPENSE REPORT

Report Date

School District ______________________ **Group No.** ________ **Date** ________ **Month**________**Year**______

1. Total number of employees – Dental Plan	____________	@	________	=	____________
2. Total number of employees – Vision Plan	____________	@	________	=	____________
3. Total number of employees – Opti-Vision	____________	@	________	=	____________
4. Total number of employees – Claim Administration Service	____________	@	________	=	____________
			SUBTOTAL (A)		

5.	____________	Employees added to Dental Plan @ ______ each	=	____________
6.	____________	Employees deleted from Dental Plan @ ______ each	=	-____________
7.	____________	Employees added to Vision Plan @ ______ each	=	+ ____________
8.	____________	Employees deleted from Vision Plan @ ______ each	=	-____________
9.	____________	Employees added to Opti-Vision Plan @ ______ each	=	+ ____________
10.	____________	Employees deleted from Opti-Vision Plan @ ______ each	=	-____________
11.	____________	Employees added to Claim Administration Service @ ______ each	=	+ ____________
12.	____________	Employees deleted from Claim Administration Service @ ______ each	=	- ____________
		SUBTOTAL (B)		____________
		7. TOTAL (A+B)		____________ A+B Total
		8. Total adjusted administration fee	=	____________
		9. Late payment fee (1.5% if applicable)	+	____________
		10. Net amount to be remitted	=	____________

NOTE: Please attach a Fringe Benefit Enrollment Charge Form for each employee **or** dependent change. Forward this copy with remittance to **School Claims Service, LLC,** P.O. Box 812, New Cumberland, PA 17070, and retain second copy for your records.