Billing Reconciliation Form

The Medical Trust
Church Life Insurance Corporation
1-800-480-9967

Prepared By: _____
List Bill ID: _____
Institution Name: _____
Bill Month(s)/Due Date(s): _____

INSTRUCTIONS: If you intend to pay an amount different than what has been billed due to new enrollment, changes or terminations of coverage, fill out the information below and e-mail it to BillingRecon@CPG.org. **Please indicate the List Bill ID in the SUBJECT LINE of the e-mail.** If you do not have e-mail or you prefer to fax this information, send to **(877-432-9274).**

***IMPORTANT!** All required documentation (i.e. enrollment , change forms, etc.) **MUST** be sent to the diocese/appropriate institution as usual, and should **NOT** accompany your payment.

Bill Amount: _____
Remit Amount: _____
Difference: ** _____
** SHOULD EQUAL GRAND TOTAL (3) BELOW

NAME	DETAILS OF CHANGE/COMMENTS	ADD/ CHANGE/ TERM	EFFECT DATE	PLAN	DATE DOCS SENT	AMOUNT

TOTAL (1) 0

MISCELLANEOUS: Please give a brief explanation why the amount you are paying is different from the amount billed if not due to an addition, termination or change. Use additional sheets if necessary.

DETAILS OF CHANGE/COMMENTS	AMOUNT

TOTAL (2) 0
** **GRAND TOTAL** (3) 0

Form BR1 (11/03)

**** PLEASE DO NOT MAIL WITH YOUR PAYMENT ****

CHURCH PENSION GROUP