



P.O. Box 797
Greenland, NH 03840-0797

**Federal Employees Dental and Vision Insurance
Program (FEDVIP)
Statement of Dental Premium Due**

[Month Day, 20XX]

DB01
Mr. John D. Doe
123 Main St.
Anytown MD 00001

Regular Premium Amount:	\$XX.XX
Previous Balance:	\$XX.XX
Amount Paid to Date:	\$XX.XX
Paid Through Date:	MM/DD/YYYY

Current Amount Due:	\$XX.XX
Due Date:	MM/DD/YYYY

**Your BENEFEDS User ID:
userid@email.com**

As explained in our letter dated [Month Day, 20XX], this is a bill for [Carrier Name] [Dental/Vision] plan premium we were unable to collect through Payroll deduction. Any payment you have made on your uncollected premium balance after [Month Day, 20XX] is not reflected on this bill.

BENEFEDS forwards your [Dental/Vision] premiums to your carrier on your behalf. If you use an online payment service, please be sure to include your member ID, XXXXXXXXXXXX, as your FEDVIP account number on the memo line.

If you have questions about this bill, please call our Customer Service Center at 1-877-888-FEDS (1-877-888-3337) (TTY 1-877-889-5680) Monday through Friday from 9:00 a.m. to 7:00 p.m. Eastern time. If you need to change your mailing or email address, please log on to your account at www.BENEFEDS.com or call our Customer Service Center.



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Please return this portion with your payment

Make Check Payable to: *Federal Employees Dental and Vision Insurance Program (FEDVIP)*

Amount Paid: \$ _____

Due Date: [Month Day, 20XX]
Amount Due: \$XX.XX

DB01
Mr. John D. Doe
123 Main St.
Anytown MD 00001

BENEFEDS-FEDVIP
PO Box 414095
Boston MA 02241-4095

