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Mail Original with Remittance and make Inquiries to:

NATIONAL EMPLOYEES
HEALTH PLAN
PO BOX 55459
DETROIT MI 48267

ACCOUNT NAME AND ADDRESS
ABC COMPANY **12345 MAIN ST** **ANYTOWN, MI 48123**

EMPLOYERS CONTRIBUTION REPORT		Based on Wks. Worked Mo. Ending
ACCOUNT NO.	DUE DATE	
456	**7/10/2000**	**Jun 2000**

TERMINATIONS AND NON-CONTRIBUTIONS

ENTER STATUS CHANGE DATE (IF NO CONTRIBUTION, LINE OUT RATE)

T - TERMINATED	L. - LAID OFF (TEMPORARY)
W - DISABLED	V - LEAVE OF ABSENCE
S - INSUFFICIENT HOURS	R - RETIRED
	X - DECEASED

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ENTER THE FOLLOWING ON THE LINE(S) BELOW THE LAST NAME PRINTED EMPLOYEE NAME, SOC. SEC. NO., STATUS CHANGE. (HIRE DATE) AND WEEKS PAID FOR.

NEW HIRES

Payments are due no later than the 10th of each month, pursuant to the regulations of ERISA. The Trustees of the Fund established a Delinquency Control Program which will be strictly enforced. Failure to pay on time may result in interest charges and liquidated damages.

EMPLOYEE NAME	LOCAL	SOC. SEC. NO.	WEEKS ENDING 3	10	17	24		WKS. PAID FOR	CODE	EMP. STATUS CHANGE DATE
(5) **DAVIS, GEORGE**	**769**	**123-45-6789**	X	X	X	X		4 (7)		
JONES, TOM	**769**	**098-76-5432**	X	X	X	-		3	T	6/16/2000 (8)
SMITH, JOHN	**769**	**543-12-6789**	X	X	X	X		4		
										DATE OF HIRE
NELSON, WENDY	769	482-37-0502		X	X	X		3		6/12/2000 (9)

(1)	TOTAL WEEKS	**14**	(10)
(2)	RATE PER WEEK	**137.50**	(11)
(3)	DUE THIS PAGE (1 x 2)	**1925.00**	(12)
TOTAL DUE (sum of line 3's)		**1925.00**	(13)

DUE THIS PAGE **1925.00**

TOTAL DUE **$1,925.00**

MAKE CHECK PAYABLE TO:

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NATIONAL EMPLOYEES
HEALTH PLAN
PO BOX 55459
DETROIT MI 48267

IMPORTANT *- Column (d) must be completed for all non-contributions*

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CERTIFIYING SIGNATURE ____________________ DATE ____________ PHONE NO ____________ 17

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WEEKLY SAMPLE