COMMISSION INVOICE

Broker Agency Name
Address Line 1
City, State, Zip
Tax ID / NPN: ___________

Invoice #: ___________
Date: ___________
Due Date: ___________

Bill To (Carrier/Payer):

Insurance Carrier Name
Accounts Payable Dept.
Address Line 1
City, State, Zip

Group Policy Details:

Group Name: ___________
Policy Number: ___________
Coverage Period: ___________

Description of Service / Plan Type	Subscriber Count	Premium Amount	Comm. % / PEPM	Total Due
Group Health Insurance Commission		$		$
Dental/Vision Riders		$		$
Administrative / Service Fees				$

Subtotal: $___________

Adjustments: $___________

Total Commission: $___________

Payment Instructions: Please make checks payable to [Broker Agency Name] or via ACH to Account: ___________ Route: ___________

Thank you for your business.