



# Extended Health Care Plan Enhanced Dental Plan (In-Scope) MONTHLY CONTRIBUTION REPORT

TO:	EMPLOYEE Benefit Programs 3sHealth 700-2002 Victoria Avenue Regina, SK S4P 0R7	ORGANIZATION NAME:	
		ORGANIZATION NUMBER:	
		Details of premium remittance for the month of:	,

Affiliation	Total Monthly Regular Salary	Retro Salary	Total Salary	Rate	Contributions	Adjustments	Total Monthly Contributions
CUPE							
SEIU							
SUN							
HSAS							
SGEU							
RWDSU							

TOTAL

Authorized By: \_\_\_\_\_  
Date: (mm/dd/yyyy) \_\_\_\_\_

Contact Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**PLEASE DO NOT STAPLE CHEQUE TO REMITTANCE FORM**