|  |  |  |
| --- | --- | --- |
|  |  | **HEALTH INSURANCE INVOICE**  |
| **FROM** |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | **INVOICE #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |
| **BILL TO** |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

|  |  |
| --- | --- |
| **DESCRIPTION** | **AMOUNT ($)** |
|  |  |
| **NOTES**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **SUBTOTAL** |  |
| **DISCOUNT** |  |
| **TAX / VAT** |  |
| **SHIPPING** |  |
| **TOTAL** |  |

THANK YOU FOR YOUR BUSINESS