Transmittal Memorandum
Medicare Part D Work-Product
Username_____
Password_____
New Plan and New Valuation

Addressees

Addressee Number 1

Company Name_____ID_____

Address_____

City_____State_____Zip_____

Tel._____Fax_____

Email_____Contact_____

Addressee Number 2

Company Name_____ID_____

Address_____

City_____State_____Zip_____

Tel._____Fax_____

Email_____Contact_____

Addressee Number 3

Company Name_____ID_____

Address_____

City_____State_____Zip_____

Tel._____Fax_____

Email_____Contact_____

Plans

Name_____ID_____

Addressee: Number 1_____Number 2_____Number 3_____

Valuations

Valuation Number_____

Test Year_____ Benchmark Prem._____

Benefit Parameters

Benefit Group	Beg. Value	End. Value
A	_____	_____
B	_____	_____
C	_____	_____

Experience Period

From_____To_____No. of Mos._____

Benefit Variables

Group	No. of Claimants	Submitted Claims	Paid Claims
A	_____	_____	_____
B	_____	_____	_____
C	_____	_____	_____
D	_____	_____	_____

Monthly Contribution per Retiree _____