

Democratic Party of Virginia
919 East Main Street, Suite 2050
Richmond, VA 23218

Amalgamated Bank
FEDERAL ACCOUNT
1-337/260

4765

2/25/2016

PAY TO THE
ORDER OF

United Healthcare

\$ 3,088.07

Three thousand eighty-eight Dollars & 7/100

DOLLARS

PROTECTED AGAINST FRAUD

\$50,000+ Needs Two Signatures

Void After 90 Days

Thomas Be...

United Healthc.
Dept. CH 1015
Palatine, IL 60

⑈004765⑈ ⑆026003379⑆ 151021389⑈

Democratic Party of Virginia
02/25/2016

4765

Date 02/24/2016 Type Bill

DPVA Federal Accou

Democratic Party of Virginia
02/25/2016

4765

Date 02/24/2016 Type Bill

DPVA Federal Accou

PAYMENT
RECORD



102531

Democratic Party of Virginia
919 East Main Street, Suite 2050
Richmond, VA 23218

Amalgamated Bank
STATE ACCOUNT
1-337/260

2200

02/25/2016

PAY TO THE ORDER OF United Healthcare \$ **1,839.06
One thousand eight hundred thirty-nine and 06/100*****
DOLLARS

United Healthcare
Dept. CH 10151
Palatine, IL 60055-0151

PROTECTED AGAINST FRAUD

\$50,000+ Needs Two Signatures

VOID AFTER 90 DAYS

Thomas Bee

MEMO

⑈002200⑈ ⑆026003379⑆ 151021400⑈

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Details on Back
Intuit® CheckLock™ Secure Check

Date	Type	Reference	Original Amount	Balance Due	Payment
02/25/2016		United Healthcare			2200
02/24/2016	Bill		4,927.13	1,839.06	1,839.06
			Check Amount		1,839.06

DPVA Non Federal 1,839.06

Date	Type	Reference	Original Amount	Balance Due	Payment
02/25/2016		United Healthcare			2200
02/24/2016	Bill		4,927.13	1,839.06	1,839.06
			Check Amount		1,839.06

DPVA Non Federal 1,839.06

PAYMENT RECORD

VADEMS

EXPENSE AUTHORIZATION

EXPENSE INFORMATION:

Requested By: Tom Total Amount: \$ 4927.13

Date: 2/24/16 Purpose: Health Insurance

VENDOR / PAYEE INFORMATION:

Name: UnitedHealthcare

Address: _____

City: _____ State: _____ Zip: _____

AUTHORIZATION:

Bank: FEDERAL STATE Budget Line: Health/Dental

Chief Operating Officer: 

Executive Director: _____

Chairwoman: _____

Expenditures must be authorized before the can funds can be committed.

ATTACH ALL RECEIPTS

All requests must be submitted with full documentation within 30 days to the Operations Department.

UnitedHealthcare
 Dept. CH 10151
 600550151C0009
 Palatine, IL 60055-0151



Page: 1 of 4

DEMOCRATIC PARTY OF VIRGINIA
 TOM BUNEO
 919 EAST MAIN STREET SUITE 2050
 RICHMOND, VA 23219

Invoice No: 0040029496
 Invoice Date: Feb 18, 2016
Customer No: 668857
Bill Group: 1
 Coverage Period: 03/01-03/31/2016
 Due Date: Mar 01, 2016

Account Summary

Previous Balance	\$-2,836.97
Payments (-)	\$0.00
Bill Group Adjustments (+/-)	\$0.00
Late Payment Charge (+)	\$0.00
Current Charges (+)	
40029496	\$7,306.47
Current Adjustments (+/-)	
0040029625	\$457.63
Total Balance Due	\$4,927.13

Invoice Summary

Description	Employee Count	Total Volume (000's)	Rate	Net Amount
01U5308-DEMOCRATIC PARTY OF VIRGINIA				
CHOYC+				
EMPLOYEE	12		-	\$5,450.16
EMPLOYEE & CHILD(REN)	1		-	\$885.65
EMPLOYEE & SPOUSE	1		-	\$908.36
Vision				
EMPLOYEE	12		-	\$65.40
EMPLOYEE & CHILD(REN)	1		-	\$13.46
EMPLOYEE & SPOUSE	1		-	\$11.44
Subtotal - 01U5308-DEMOCRATIC PARTY OF VIRGINIA	28		-	\$7,334.47
Packaged Savings Administrative Credit				
Subtotal - Packaged Savings Administrative Credit			-	\$-28.00

Please Detach and Return the Portion Below with Remittance

Customer Name DEMOCRATIC PARTY OF VIRGINIA	Customer Number 668857	Payment Due Date Mar 01, 2016	INV # C0040028460
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Return payment stub to:

UnitedHealthcare Insurance Company
 Dept. CH 10151
 Palatine, IL 60055-0151

AMOUNT DUE

\$4,927.13

AMOUNT PAID

\$ _____

DEMOCRATIC PARTY OF VIRGINIA
 TOM BUNEO
 919 EAST MAIN STREET SUITE 2050
 RICHMOND, VA 23219

Invoice No: 0040029496
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 Coverage Period: 03/01-03/31/2016
 Due Date: Mar 01, 2016

Invoice Summary

Description	Employee Count	Total Volume (000's)	Rate	Net Amount
TOTAL	28		-	\$7,306.47

Invoice Detail

Policy No.	Name	Plan	ID	Coverage	Volume (000's)	Charge Amount
01U5308	ARMITAGE, TRENT F	CHOYC+	045809440-00	E		4 \$454.18
01U5308	BANKS, KRISTOPHER	CHOYC+	363080495-00	E		\$454.18
01U5308	BOLLING, JON CHRISTOPHE	CHOYC+	226338327-00	E		\$454.18
01U5308	BOLTON, EMILY	CHOYC+	319823750-00	E		\$454.18
01U5308	BUNEO, THOMAS	CHOYC+	076785161-00	E		\$454.18
01U5308	CANNAN, GEORGINA C	CHOYC+	225458606-00	E		\$454.18
01U5308	CUTRIGHT, JOSEPH C	CHOYC+	228636139-00	E		\$454.18
01U5308	MANISCALCO, JAMIE L	CHOYC+	053784382-00	E		\$454.18
01U5308	NOLAN, JAMIE D	CHOYC+	228312956-00	E		U \$454.18
01U5308	NORDIN, KEES	CHOYC+	574080223-00	E		\$454.18
01U5308	RAMAN, SHYAM	CHOYC+	022764196-00	E		\$454.18
01U5308	SLUTZKY, REBECCA L	CHOYC+	348825788-00	E		\$454.18

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Invoice Detail

Policy No.	Name	Plan	ID	Coverage	Volume (000's)	Charge Amount
01U5308	TOBE, BRENNER A	CHOYC+	303882770-00	EC		\$885.65
01U5308	SOUTHERLAND, TREVOR M	CHOYC+	411652056-00	ES		H \$908.36
01U5308	ARMITAGE, TRENT F	Vision	045809440-00	E		H \$5.45
01U5308	BANKS, KRISTOPHER	Vision	363080495-00	E		\$5.45
01U5308	BOLLING, JON CHRISTOPHE	Vision	226338327-00	E		\$5.45
01U5308	BOLTON, EMILY	Vision	319823750-00	E		\$5.45
01U5308	BUNEO, THOMAS	Vision	076785161-00	E		\$5.45
01U5308	CANNAN, GEORGINA C	Vision	225458606-00	E		\$5.45
01U5308	CUTRIGHT, JOSEPH C	Vision	228636139-00	E		\$5.45
01U5308	MANISCALCO, JAMIE L	Vision	053784382-00	E		\$5.45
01U5308	NOLAN, JAMIE D	Vision	228312956-00	E		J \$5.45
01U5308	NORDIN, KEES	Vision	574080223-00	E		\$5.45
01U5308	RAMAN, SHYAM	Vision	022764196-00	E		\$5.45
01U5308	SLUTZKY, REBECCA L	Vision	348825788-00	E		\$5.45
01U5308	TOBE, BRENNER A	Vision	303882770-00	EC		\$13.46

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Policy No.	Name	Plan	ID	Coverage	Volume (000's)	Charge Amount
01U5308	SOUTHERLAND, TREVOR M	Vision	411652056-00	ES		H \$11.44
01U5308	Packaged Savings Credit	Packaged Savings Credit	000000000-00			\$-28.00
TOTAL:						\$7,306.47

PLEASE VISIT EMPLOYER ESERVICES AT WWW.EMPLOYERESERVICES.COM TO perform real-time eligibility transactions, view and pay your invoices, request ID cards and more!

Employee and dependent information contained in this report is based on the most current information provided by the Employer, acting as Plan Sponsor and/or Plan Administrator (the organization which established the employee welfare plan for its employees) to the Company (a division of UnitedHealth Group contractually administering claims on behalf of the Employer). Changes to employees and dependent information are the responsibility of the Employer, acting as Plan Sponsor and/or Plan Administrator, and must be submitted to the Company on a timely basis. Please do not submit employee changes by noting them on this invoice. This address is used for payment purposes only and written instructions sent to this address will not be processed.

FED: 3088.07
 H: 1379.43
 J: 459.63

To keep your group insurance coverage in effect, it is important that we receive full payment of all amounts due, as required by your Group Contract/Policy. If your Group Contract/Policy requires an initial advance notice of termination for non-payment of premium, this statement will serve as the required initial advance notice of termination that will be effective in accordance with your Group Contract/Policy.

Balance reflected is as of the invoice date and may be subject to change pending verification of payment or direct debit bank processing. Any changes will be reflected on your next invoice.

Applicable to Employers with Enrollees residing in Texas: Employers are responsible for premiums on Enrollees who are no longer eligible for group coverage until the end of the month in which you notify UnitedHealthcare of the Enrollee's termination. UnitedHealthcare's preferred method for notification of termination of coverage is through Employer eServices at www.employereservices.com.

Please contact your Billing/Accounts Receivable Representative if you have any questions. Thank you. 1-888-842-4571

This invoice covers eligibility charges from the following entities:
 UnitedHealthcare Insurance Company