SONO GRATO INSURANCE

Employee Benefit Form

Please fill out the form accurately to ensure timely processing of your benefits.

Full Name: ____________________ SSN: ____________

Residential Address: ______________________________

City: ____________ State: __________ Zip Code: ________

Date of Birth: ____________ Cell Number: ____________

Email Address: ______________________________

Location: ____________________ Job Title: ____________

Wage: ________ Hire Date: __________

Benefit Selection

Please select the benefits you wish to enroll in or update:

- ☐ Vision Insurance
- ☐ Term Life Insurance
- ☐ Whole Life Insurance – Guaranteed Issue up to $100,000 lifelong coverage
- ☐ Disability Insurance
- ☐ Accident insurance
- ☐ Critical Care/Cancer Insurance
- ☐ Virtual Care Therapy Coverage

- ☐ Waive all benefits offered. By checking this box, I understand that I will not be eligible for benefits until next annual open enrollment.

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Dependent Information

Please provide details of any dependents you wish to include in your benefits:

Full Name	Relation	Date of Birth	Gender	Social Security Number

Vision Insurance Deduction (semi-monthly)

VSP 12/12/12 $10 office visit $25 material fee $180 material coverage

- ☐ EE Only
- ☐ EE + 1
- ☐ EE + Children
- ☐ Family

Whole Life Insurance Deduction (semi-monthly)

Permanent Coverage, Guaranteed Issue Coverage up to $100k, Coverage above $100k subject to uw, Spouse rider and child rider available

Current Age: ______ Face Amount: ____________Whole Life deduction: ___________

Beneficiary's Legal name: _________________________________ M/F %: ____________

Date of Birth: ________________ Relationship: ___________________ Cell: _______________

Address: ____

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Term Life Insurance Deduction (semi-monthly)

20 year Term - Spouse rider and child rider available

☐ Life insurance: Face Amount: ______________ Deduction: ____________

Disability Insurance Deduction (semi-monthly)

Elim. Period: 0/7 0/14 Weekly Benefit Amount: ____________

Deduction: _____________

Supplemental Insurance Deduction (semi-monthly)

☐ Accident Insurance: Level 1 Level 2 Deduction: ______________

- EE Only
- EE/Spouse
- EE/Children
- Family

☐ Critical illness: Face Amount: ____________ Deduction: ______________

- EE/Children
- EE/Spouse/Children

Total Insurance Deduction (semi-monthly): ______________

Authorization and Signature

By signing below, I authorize the processing of my selected benefits. I understand that any misrepresentations or omissions may result in the termination of benefits and/or employment.

Employee Signature: _____________________________________ Date: _______________