

<p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: x-small;">This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; text-align: center;">2023</p> <hr/> <p style="text-align: center;">This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. ▶

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>TERUMO PUERTO RICO LTD</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>TERUMO PUERTO RICO LLC</u></p> <p><u>265 DAVISON AVE STE 320</u> <u>SOMERSET, NJ 08874</u></p> <p><u>265 DAVISON AVE STE 320</u> <u>SOMERSET, NJ 08874</u></p>	<p>1c Effective date of plan <u>02/01/2017</u></p> <p>2b Employer Identification Number (EIN) <u>66-0868014</u></p> <p>2c Plan Sponsor's telephone number <u>732-302-4985</u></p> <p>2d Business code (see instructions) <u>541990</u></p>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/29/2024	JANET HELLWIG
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/29/2024	JANET HELLWIG
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	393
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	393
	6a(2)	371
	6b	
	6c	
	6d	371
	6e	
	6f	371
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4H

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules		b General Schedules	
(1) <input type="checkbox"/> R (Retirement Plan Information)		(1) <input type="checkbox"/> H (Financial Information)	
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) <input type="checkbox"/> I (Financial Information – Small Plan)	
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>1</u>	
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____		(4) <input type="checkbox"/> C (Service Provider Information)	
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)		(5) <input type="checkbox"/> D (DFE/Participating Plan Information)	
		(6) <input type="checkbox"/> G (Financial Transaction Schedules)	

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **01/01/2023** and ending **12/31/2023**

A Name of plan TERUMO PUERTO RICO LTD	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 TERUMO PUERTO RICO LLC	D Employer Identification Number (EIN) 66-0868014

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	SGD608554	371	01/01/2023	12/31/2023

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 7624	(b) Total amount of fees paid 1906
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
CENTRAL GROUP INSURANCE AGENCY, INC **PO BOX 1868**
DORADO, PR 00646

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7624	1906	INSURANCE SERVICES	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MARSH SALDANA INC **PO BOX 9023549**
SAN JUAN, PR 00902

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7624		BROKER	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶		
b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year.....	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶		
b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits	7c(2)	
(3) Interest credited during the year	7c(3)	
(4) Transferred from separate account.....	7c(4)	
(5) Other (specify below)	7c(5)	
▶		
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier	7e(2)	
(3) Transferred to separate account.....	7e(3)	
(4) Other (specify below)	7e(4)	
▶		
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	38118	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
	(3) Increase (decrease) in unearned premium reserve	9a(3)		
	(4) Earned ((1) + (2) - (3)).....	9a(4)		38118
b	Benefit charges (1) Claims paid.....	9b(1)		
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2)).....	9b(3)		
	(4) Claims charged	9b(4)		
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions	9c(1)(A)	7624	
	(B) Administrative service or other fees	9c(1)(B)	1906	
	(C) Other specific acquisition costs	9c(1)(C)		
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies.....	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention	9c(1)(H)		9530
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
	(2) Claim reserves	9d(2)		
	(3) Other reserves.....	9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶



Terumo Puerto Rico, LLC
265 DAVIDSON AVENUE
SUITE 320
SOMERSET NJ 08873

January 1, 2024

Dear Valued Customer:

The enclosed report provides some important information regarding your group insurance policy for the recently completed policy year. This information includes, among other things, total premiums paid, as well as compensation paid to agents or brokers in connection with your policy.

If your policy is issued in connection with an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), then you will find this information useful in preparing the ERISA annual report (Form 5500). Please contact your attorney or benefits consultant if you have questions regarding the applicability of ERISA to your plan, Form 5500, or other requirements. We hereby certify that the information provided here is accurate and complete.

If your policy is not subject to ERISA, then we are providing this information as a service, for your use in the management of your benefit plan. Our goal is to provide the highest degree of service to our customers, and we are committed to providing this important information to you.

This information may include an entry which shows other compensation received by your broker from New York Life Group Benefit Solutions, in addition to commissions. New York Life Group Benefit Solutions companies offer programs under which agents and brokers can qualify for additional compensation, based on meeting new sales and persistency goals, for providing our insurance companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. For plans subject to ERISA and required to file Form 5500, the U.S. Department of Labor has advised that such payments must be reported on Schedule A of Form 5500. Thus, if your broker received a payment during the policy year under that program, a portion (equal to the amount, which was based on premiums or commissions, that the program generated with respect to the policy) has been allocated and is included with the Schedule A information that is enclosed. While this compensation has been, for this purpose, allocated to specific policies, it is funded from our general overhead for all policies, regardless of whether a broker participates in these agreements. Note: these payments, where applicable, are labeled as overrides. If a zero dollar figure is shown, it means that no such payment was paid to your broker during the policy year.

Your agent or broker may also have participated, at the insurance company's expense, in producer events sponsored by our insurance companies during which information concerning our products and services was exchanged. Please contact your agent or broker if you would like specific information about their participation in these programs. In addition, the insurance company offers agents and brokers the opportunity to receive the benefit of New York Life's favorable pricing with vendors of various goods and services.

New York Life Group Benefit Solutions has a longstanding commitment to our customers to deliver the highest level of quality service. Millions of individuals continue to rely on New York Life Group Benefit Solutions for the Insurance protection they need. We value the trust our customers place in us, and unwaveringly pledge to adhere to ethical business standards.

Sincerely,


Carol L. Bailey
Carol L. Bailey
Revenue Management



Terumo Puerto Rico, LLC
265 DAVIDSON AVENUE
SUITE 320
SOMERSET, NJ 08873

Date Prepared: January 1, 2024

Anniversary
Annual Policy Information Report

Name of Insurance Carrier Life Insurance Company of North America	
EIN	23-1503749
NAIC Code	65498
Contract/Policy Number	SGD0608554
Contract/Policy Year From:	01/01/2023
Contract/Policy Year To:	12/31/2023

Policy or Benefit Type
LTD Fully Insured Basic Group

Approximate Number of persons covered at the end of the policy year:*

**Please refer to your census reports or billing statement for this information.*

Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.

Total premiums paid to Insurance Company during the policy year: \$ 38,117.88

See below for total commissions and fees paid by Insurance Company during the policy year.

Agent Number	Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
CGI-01890	MARSH SALDANA INC PO BOX 9023549 SAN JUAN PR 00902	\$7,623.57	\$ 0.00	Standard Commissions
CGI-02749	CENTRAL GROUP INSURANCE AGENCY, INC. PO BOX 1868 DORADO PR 00646	\$1,905.89	\$ 0.00	Standard Commissions
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact a Revenue Management representative at 800.243.7445.

Bill for 12/01/2023 - 12/31/2023 | 121372_120123

Bill Overview

SUMMARY	ADMIN DETAILS	REFERENCES	PAYMENT	PROCESSING
Due Date 12/31/2023	Bill status PUBLISHED	Billing account name TERUMO PUERTO RICO LLC	Payment date 12/27/2023	Payment status Offline Payment Selected
Bill total \$14,376.81	Client Terumo Puerto Rico, LLC	Billing account ID 121372	Bank account -	
Commission \$0.00	Billing frequency Monthly	Bill ref 121372_120123	Submitted by Debbie Piscadlo	DELINQUENCY
Receivables total \$14,376.81	Generation date 12/01/2023 00:51	Version 001	Online payment amount -	Tracking setting Automatically tracked
Applied total \$14,376.81				Automated setting Bill currently tracked for delinquency
Published date 12/01/2023 00:51				
Current coverage period 12/01/2023 - 12/31/2023				

Current Coverage Period
12/01/2023 - 12/31/2023

Total for Current Coverage Period
\$14,376.81

Product	Policy Ref							Subtotal
Basic Term Life	SGM-0608068							\$6,072.04
Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1000 of Total Benefit	No. of Insured Employees	Total Benefit	Amount	
Employee	001	Multiple of earnings	2 times annual earnings	0.16	371	\$23,532,000.00	\$3,765.12	
Insured Tier	Class	Benefit	Level Of Coverage	Rate per Insured Employee	No. of Insured Employees	Amount		
Dependents	001	Flat	10,000.00 (spouse); 5,000.00 (child)	7.49	308	\$2,306.92		
Product	Policy Ref							Subtotal
Voluntary Term Life	SGM-0608068							\$1,762.77
Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1 of Total Benefit	No. of Insured Employees	Total Benefit	Amount	
Employee	001	Units	Units of 25,000 between 25,000-300,000	1.00	100	\$1,544.06	\$1,544.06	
Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1 of Total Benefit	No. of Insured Employees	Total Benefit	Amount	
Spouse	001	Units	Units of 10,000 between 10,000-	1.00	27	\$167.71	\$167.71	

100,000

Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1000 of Total Benefit	No. of Insured Employees	Total Benefit	Amount
Child	001	Units	Units of 2,500 between 2,500-10,000	0.20	28	\$255,000.00	\$51.00

Product Basic AD&D	Policy Ref SOK-0605900						Subtotal \$894.22
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Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1000 of Total Benefit	No. of Insured Employees	Total Benefit	Amount
Employee	001	Multiple of earnings	2 times annual earnings	0.038	371	\$23,532,000.00	\$894.22

Product Voluntary AD&D	Policy Ref SOK-0605900						Subtotal \$200.55
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Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1000 of Total Benefit	No. of Insured Employees	Total Benefit	Amount
Employee	001	Units	Units of 25,000 between 25,000-300,000	0.03	84	\$5,675,000.00	\$170.25

Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1000 of Total Benefit	No. of Insured Employees	Total Benefit	Amount
Spouse	001	Units	Units of 10,000 between 10,000-100,000	0.03	25	\$770,000.00	\$23.10

Insured Tier	Class	Benefit	Level Of Coverage	Rate per 1000 of Total Benefit	No. of Insured Employees	Total Benefit	Amount
Child	001	Units	Units of 2,500 between 2,500-10,000	0.03	27	\$240,000.00	\$7.20

Product Long Term Disability	Policy Ref SGD-0608554						Subtotal \$5,447.23
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Insured Tier	Class	Benefit	Level Of Coverage	Rate per 100 of Monthly Covered Payroll	No. of Insured Employees	Monthly Covered Payroll	Amount
Employee	001	% of earnings	60.0% of monthly covered earnings	0.56	371	\$972,720.00	\$5,447.23

Adjustments

Product	Policy Ref	Benefit Type	Adjust To Zero	Amount Before	Adjustment Amount	Amount After	Reason	Comment	Adjustment Amount
Long Term Disability	SGD-0608554	Basic	No	\$5,447.23	\$0.00	\$5,447.23	-	-	\$0.00
Basic Term Life	SGM-0608068	Basic	No	\$6,072.04	\$0.00	\$6,072.04	-	-	\$0.00
Voluntary Term Life	SGM-0608068	Voluntary	No	\$1,762.77	\$0.00	\$1,762.77	-	-	\$0.00
Basic AD&D	SOK-0605900	Basic	No	\$894.22	\$0.00	\$894.22	-	-	\$0.00
Voluntary AD&D	SOK-0605900	Voluntary	No	\$200.55	\$0.00	\$200.55	-	-	\$0.00

Current Coverage Period

\$14,376.81

Adjustments for Prior Coverage Periods	\$0.00
Bill Total	\$14,376.81
Variance	0.43%