Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110

2024

This Form is Open to Public Inspection

Part I	Annual Report lo	dentification Information			
For calenda	ar plan year 2024 or fisc	cal plan year beginning 01/01/2024	and ending 12/31/2024		
A This retu	urn/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this be employer information in accordance with the fo		
		X a single-employer plan	a DFE (specify)		
B This retu	urn/report is:	the first return/report	the final return/report		
		an amended return/report	a short plan year return/report (less than 12 mo	onths)	
C If the pla	an is a collectively-barg	ained plan, check here			
D Check b	ox if filing under:	Form 5558	automatic extension	the DFVC program	
		special extension (enter description	n)		
E If this is	a retroactively adopted	plan permitted by SECURE Act section	201, check here		
Part II	Basic Plan Infor	mation—enter all requested information	n		
1a Name o	•	RATED INDIVIDUAL BENEFIT ACCOUN		1b Three-digit plan number (PN) ▶ 501	
				1c Effective date of plan 06/01/1984	
Mailing City or	address (include room town, state or province	er, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box) n, country, and ZIP or foreign postal code	(if foreign, see instructions)	2b Employer Identification Number (EIN) 54-1279046	
ZETA ASS	OCIATES INCORPOR	ATED		2c Plan Sponsor's telephone number 703-385-7050	
10302 EAT SUITE 500 FAIRFAX,				2d Business code (see instructions) 541700	

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. Signature of plan administrator	05/01/2025 Date	SUE SUK Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	05/01/2025	SUE SUK
HEIKE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HEKE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

	Form 5500 (2024)	P	age 2		
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Administra	tor's EIN
				3c Administra	tor's telephone
				namber	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name. EIN, the plan name and the plan number from			4b EIN	
а	Sponsor's name			4d PN	
С	Plan Name				
5	Total number of participants at the beginning of the plan year			5	266
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2) , 6b , 6c , and 6d).	(welfare pla	ans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year			6a(1)	266
а(2) Total number of active participants at the end of the plan year			6a(2)	201
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.			6d	201
e	Deceased participants whose beneficiaries are receiving or are entitled to			6e	
f	Total. Add lines 6d and 6e			6f	
g(complete this item)			6g(1)	
g(Number of participants with account balances as of the end of the plan year complete this item)			6g(2)	
h	Number of participants who terminated employment during the plan year w less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only n				
8a	If the plan provides pension benefits, enter the applicable pension feature coo	des from the	List of Plan Characteristics Cod	es in the instructi	ons:
b	If the plan provides welfare benefits, enter the applicable welfare feature code	es from the L	List of Plan Characteristics Code	s in the instruction	ns:
	4A 4B 4D 4E 4F 4H 4I 4L				
9a	Plan funding arrangement (check all that apply)	9b Plan b	benefit arrangement (check all th	at apply)	
	(1) Insurance	(1)	X Insurance		
	Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance contra	icts
	(3) Trust (4) General assets of the sponsor	(3) (4)	Trust X General assets of the s	nonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are att			·	ee instructions)
а	Pension Schedules	b Gene	eral Schedules	•	,
	(1) R (Retirement Plan Information)	(1)	H (Financial Information	n)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Information	n – Small Plan)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	A (Insurance Information	on) – Number Atta	ached 10
	actuary	(4)	C (Service Provider Info	ormation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5)	D (DFE/Participating Pl	an Information)	
	(4) DCG (Individual Plan Information) – Number Attached	(6)	G (Financial Transaction	n Schedules)	
	(5) MEP (Multiple-Employer Retirement Plan Information)		_		

No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 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_____

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

2024

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)				Inspection
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024							
A Name of plan ZETA ASSOCIATES INC	ORPORATED) INDIVIDUAL BENEFIT ACCO	UNT	B Three plan	e-digit number (PI)	501
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)
ZETA ASSOCIATES INC	ORPORATED)		54-	1279046		
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		E COMPANY AND AFFILIATES	5				
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
59-1031071	67369	3334243	672		01/01/202	24	12/31/2024
2 Insurance fee and coming descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
164779 4304							
3 Persons receiving com		ees. (Complete as many entrie					
		and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF INSURANCE SI	ERVICES, INC		RLOTTE RLOTTE, NC 27214				
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	144661	4304	SERVICE/GEN AGENT I	FEE			3
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF INSURANCE SI	MCGRIFF INSURANCE SERVICES, INC. CHARLOTTE CHARLOTTE, NC 27214						
(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	20118						

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Tops and other commissions noid	(0)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
commissions paid	· · · · · · · · · · · · · · · · · · ·		code	
(=) N =				
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base			Organization	
commissions paid	(c) Amount	(d) Purpose	code	
•				
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid		
			1	
		Fees and other commissions paid	(e)	
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization	
commissions paid	(c) Amount	(u) 1 dipose	code	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Tops and other commissions noid	(0)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
commodicino para	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000	
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid		
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base			Organization	
commissions paid	(c) Amount	(d) Purpose	code	
•				

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

	0	t III Welfare Benefit Contract Information						_
r	art	If more than one contract covers the same group of employees of the the information may be combined for reporting purposes if such cont employees, the entire group of such individual contracts with each care.	racts are	exp	erience-rated as a un	it. Where co	ontracts cover individual	
8	Ber	enefit and contract type (check all applicable boxes)						
	a			c 🔯	Vision		d Life insurance	
	_ [_	-			
	e	Temporary disability (accident and sickness) f Long-term disabili	-	g _	-	ipioyment	h X Prescription drug	
	ı	Stop loss (large deductible) j HMO contract		k _	PPO contract		I X Indemnity contract	
	m	Other (specify)						
9	Ехр	perience-rated contracts:		-			_	
	а	Premiums: (1) Amount received	9a(1)		<u> </u>	2459258	_	
		(2) Increase (decrease) in amount due but unpaid	9a(2)		<u> </u>	4225	<u> </u>	
		(3) Increase (decrease) in unearned premium reserve	9a(3)			0-(4)	24634	02
	h	(4) Earned ((1) + (2) - (3))				9a(4) 3849306		<u> </u>
	b					44549		
		(2) Increase (decrease) in claim reserves				9b(3)	38938	55
		(3) Incurred claims (add (1) and (2))(4) Claims charged				9b(4)	38938	
	С					35(4)		
	•	(A) Commissions	9c(1)(Δ)				
		(B) Administrative service or other fees	9c(1)(l					
		(C) Other specific acquisition costs	9c(1)(
		(D) Other expenses	9c(1)(l	D)		203061		
		(E) Taxes	9c(1)(l	Ξ)		56167		
		(F) Charges for risks or other contingencies	9c(1)(l					
		(G) Other retention charges	9c(1)(3)	<u> </u>	•		
		(H) Total retention				9c(1)(H)	2592	28
		(2) Dividends or retroactive rate refunds. (These amounts were paid ir	ı cash, or	□ ·	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits a	after	retirement	9d(1)		
		(2) Claim reserves				9d(2)	5714	27
		(3) Other reserves				9d(3)		
	е		d in line 9	c(2)	.)	9e		
10	No	Nonexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a	20782	61
	b	, , ,				406		
	Sne	retention of the contract or policy, other than reported in Part I, line 2 abovecify nature of costs.	e, report	amo	ount	10b		
	Spe	bedity flature of costs.						
P	art	IV Provision of Information						_
			loto Cab-	ماريام		Yes	X No	
11		Did the insurance company fail to provide any information necessary to comp	ete Sche	uule	A (169	NO	_
12	i If f	f the answer to line 11 is "Yes," specify the information not provided.						

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

OMB No. 1210-0110

			ERISA section 103(a)(2).	imation	This Form is Open to Public Inspection
For calendar plan year 202	24 or fiscal pl	an year beginning 01/01/2024	an	d ending 12/31/202	
A Name of plan ZETA ASSOCIATES INCORPORATED INDIVIDUAL BENEFIT ACCO			LINET	Three-digit plan number (PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500 ZETA ASSOCIATES INCORPORATED D Employer Identification Number (EIN) 54-1279046					Number (EIN)
on a separa		erning Insurance Contract A. Individual contracts grouped			vide information for each contract Schedule A.
1 Coverage Information:					
(a) Name of insurance cal		RTH AMERICA			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end of		olicy or contract year
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To
23-1503749	65498	TD1960459		01/01/2024	12/31/2024
2 Insurance fee and commodescending order of the		nation. Enter the total fees and \mathfrak{t}	otal commissions paid. List in li	ne 3 the agents, broke	rs, and other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid				s paid	
45 2					
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all persor	ıs).	
	(a) Name	and address of the agent, broke	er, or other person to whom com	missions or fees were	paid
MCGRIFF INSURANCE SI	ERVICES, IN		BOX 896620 RLOTTE, NC 28289		
(b) Amount of sales an	nd base	F	ees and other commissions paid	I	
commissions pai		(c) Amount	(d) Pu	rpose	(e) Organization code
	45				3
	(a) Name	and address of the agent, broke	er or other person to whom com	missions or fees were	naid
MCGRIFF INSURANCE SI	MCGRIFF INSURANCE SERVICES, INC. 736 MARKET ST SUITE 1000 CHATTANOOG, TN 37402				
(b) Amount of sales an	nd base		ees and other commissions paid	I	
commissions pai		(c) Amount	(d) Pu	rpose	(e) Organization code
		2			3

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Tops and other commissions noid	(0)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
commissions paid	· · · · · · · · · · · · · · · · · · ·		code	
(=) N =				
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base			Organization	
commissions paid	(c) Amount	(d) Purpose	code	
•				
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid		
			1	
		Fees and other commissions paid	(e)	
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization	
commissions paid	(c) Amount	(u) 1 dipose	code	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Tops and other commissions noid	(0)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
commodicino para	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000	
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid		
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base			Organization	
commissions paid	(c) Amount	(d) Purpose	code	
•				

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

P	art	Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	oup of employees of the gurposes if such cont	tracts are expe	erience-rated as a unit	t. Where co	ntracts	cover individual
8	Ben	efit and contract type (check all applicable boxes)			_			
	а	Health (other than dental or vision)	D Dental	С	Vision		d 🗌 L	ife insurance
	е	Temporary disability (accident and sickness)	Long-term disabili	ity g	Supplemental unem	ployment	h 🗌 F	Prescription drug
	ιĪ	Stop loss (large deductible)	i ☐ HMO contract	k	PPO contract		ıΠı	ndemnity contract
	m		_		I			•
	L	- Sanor (opcony)						
9	Expe	erience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid .						
		(3) Increase (decrease) in unearned premium reser	ve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	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)		
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)				_	
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		9c(1)(B)			_	
		(C) Other specific acquisition costs		9c(1)(C)			_	
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes					_	
		(F) Charges for risks or other contingencies (G) Other retention charges					_	
		(H) Total retention(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These a	_	_				
	٨	Status of policyholder reserves at end of year: (1)				9c(2)		
	d	(2) Claim reserves	·			9d(1) 9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not				9e		
10		onexperience-rated contracts:		<u> • • • (=).</u>	·/······			
	а	Total premiums or subscription charges paid to car	rier			10a		450
	b	If the carrier, service, or other organization incurred						
	-	retention of the contract or policy, other than repor	ted in Part I, line 2 abov	/e, report amo	ount	10b		
	Spe	ecify nature of costs.						
D	- r4	IV Provision of Information						
	art					V-	√	
		d the insurance company fail to provide any informa		lete Schedule	A?	Yes	X No	
12	If t	the answer to line 11 is "Yes," specify the information	n not provided.					

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

OMB No. 1210-0110

2024

This Form is Open to Public

		pursuant to E	ERISA section 103(a)(2).				Inspection
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024							
A Name of plan				B Three	-digit		
ZETA ASSOCIATES INC	CORPORATE	D INDIVIDUAL BENEFIT ACCOU	NT	plan	number (Pl	N) •	501
				-			
C Plan sponsor's name a	as shown on li	ne 2a of Form 5500		D Employ	yer Identific	ation Number (EIN)
ZETA ASSOCIATES INC	CORPORATE	D			1279046	·	,
		erning Insurance Contract A. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		RTH AMERICA					
	() 11410	(1) 0	(e) Approximate nun	nber of		Policy or co	ntract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at o	end of	(f)	From	(g) To
23-1503749	65498	LK750914		,	01/01/202	4	12/31/2024
	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 (b) Total amount of fees paid							
12363 605							
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all pe	ersons).			
	(a) Name	and address of the agent, broker,	or other person to whom	commissi	ons or fees	were paid	
MCGRIFF INSURANCE S	ERVICES, IN		OX 896620 LOTTE, NC 28289				
(b) Amount of sales a	nd hase	Fee	es and other commissions	s paid			
commissions pa		(c) Amount	(0	d) Purpose)		(e) Organization code
	12363						3
	(a) Name	and address of the agent, broker,	or other person to whom	commissi	ons or fees	were paid	
MCGRIFF INSURANCE S			ARKET ST SUITE 1000	23111111301	23 01 1000	paid	
	zittiozo, iit		TANOOG, TN 37402				
(b) Amount of sales a	nd base	Fee	es and other commissions	s paid			
commissions pa		(c) Amount	(c	d) Purpose)		(e) Organization code
		605					3

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Tops and other commissions noid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
commissions paid	· · · · · · · · · · · · · · · · · · ·		code				
(=) N =							
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base			Organization				
commissions paid	(c) Amount	(d) Purpose	code				
•							
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid					
			1				
		Fees and other commissions paid	(e)				
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization				
commissions paid	(c) Amount	(u) 1 dipose	code				
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Tops and other commissions noid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
commodicino para	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000				
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid					
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base							
commissions paid	(c) Amount	(d) Purpose	Organization code				
•							

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

P	art I	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the	he same emplo	war(s) or mambars of	the same e	mnlovee organization	ne(e)
		the information may be combined for reporting purposes if such coremployees, the entire group of such individual contracts with each of	ntracts are expe	erience-rated as a un	it. Where co	ontracts cover individu	
8	Bene	nefit and contract type (check all applicable boxes)					
	a 🕽	Health (other than dental or vision)	С	Vision		d Life insurance	
	еĒ	Temporary disability (accident and sickness) f Long-term disabi	ility a	Supplemental unem	plovment	h Prescription dr	rua
	· i [Stop loss (large deductible)		PPO contract	,	I Indemnity cont	-
	m			I		<u></u>	
9	Exne	perience-rated contracts:					
		Premiums: (1) Amount received	9a(1)				
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium reserve					
		(4) Earned ((1) + (2) - (3))			9a(4)		
	-				.,(-/		
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))			9b(3)		
		(4) Claims charged			9b(4)		
		(A) Commissions	9c(1)(A)				
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs	- (1)(-)				
		(D) Other expenses	2 (1)(2)				
		(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))	
		(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	e benefits after	retirement	9d(1)		
		(2) Claim reserves			9d(2)		
		(3) Other reserves			9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line 9c(2)	.)	9e		
10	No	lonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier			10a		123633
	b	If the carrier, service, or other organization incurred any specific costs in	connection wit	h the acquisition or			
		retention of the contract or policy, other than reported in Part I, line 2 about			10b		
	Spe	pecify nature of costs.					
Pa	art I	IV Provision of Information					
		oid the insurance company fail to provide any information necessary to com	plete Schedule	А?	Yes	X No	
		the answer to line 11 is "Yes," specify the information not provided.	r.5to Coriodalo				
12	11 (1	the answer to line it is ites, specify the information not provided.					

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

OMB No. 1210-0110

					Inspection		
For calendar plan year 202	24 or fiscal pla	an year beginning 01/01/2024	â	and ending 12	/31/2024	•	
A Name of plan ZETA ASSOCIATES INC	ORPORATE	D INDIVIDUAL BENEFIT ACCOU		Three-digit plan number (F	PN) •	501	
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500	D	Employer Identifi	cation Number (EIN)	
ZETA ASSOCIATES INC	ORPORATE	D		54-1279046			
		erning Insurance Contrac A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance cal		RTH AMERICA					
	(a) NIAIC	(d) Contract or	(e) Approximate numbe	er of	Policy or co	ntract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract yea	17) From	(g) To	
23-1503749	65498	FLX963886		01/01/20	24	12/31/2024	
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 (b) Total amount of fees paid							
		18456				863	
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all perso	ons).			
	(a) Name	and address of the agent, broker	, or other person to whom cor	mmissions or fee	s were paid		
MCGRIFF INSURANCE SI	ERVICES, IN		BOX 896620 RLOTTE, NC 28289				
(b) Amount of sales an	nd hase	Fe	es and other commissions pa	nid			
commissions pai		(c) Amount	(d) P	urpose		(e) Organization code	
	18456					3	
	(a) Name	and address of the agent, broker	or other person to whom cor	mmissions or fee	s were paid		
MCGRIFF INSURANCE SI		C. 736 M	IARKET ST SUITE 1000 TANOOG, TN 37402				
(b) Amount of sales an	nd base	Fe	es and other commissions pa	nid	_		
commissions pai		(c) Amount	(d) P	urpose		(e) Organization code	
		863				3	

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Tops and other commissions noid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
commissions paid	· · · · · · · · · · · · · · · · · · ·		code				
(=) N =							
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base			Organization				
commissions paid	(c) Amount	(d) Purpose	code				
•							
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid					
			1				
		Fees and other commissions paid	(e)				
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization				
commissions paid	(c) Amount	(u) 1 dipose	code				
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Tops and other commissions noid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
commodicino para	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000				
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid					
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base							
commissions paid	(c) Amount	(d) Purpose	Organization code				
•							

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

Pa	art	III Welfare Benefit Contract Informa	ation				
		If more than one contract covers the same of the information may be combined for report	ting purposes if such cont	racts are expe	erience-rated as a uni	t. Where cor	ntracts cover individual
		employees, the entire group of such individu	ual contracts with each ca	arrier may be	treated as a unit for p	urposes of th	is report.
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prescription drug
	i [Stop loss (large deductible)	j ∏ HMO contract		PPO contract	,	I Indemnity contract
	m	☐ Stop loss (large deductible) X Other (specify) ► BTL FULLY INSURED, VTL	• 🗀		11 0 donardot		I Indemnity contract
	m	A Other (specify) F BTE FOLET INSORED, VTE	_ FOLLT INSURL				
0	- _{v.n.}						
		erience-rated contracts: Premiums: (1) Amount received		9a(1)			
	u	(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res					_
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid				1 0(./	
		(2) Increase (decrease) in claim reserves					_
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(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					
		(G) Other retention charges		,		0-(4)(11)	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_			9c(2)	
	d	Status of policyholder reserves at end of year: (1)				9d(1)	
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	
10	e No	Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts:	of include amount entered	u III IIIIe 90(2)	.)	9e	
	a	Total premiums or subscription charges paid to c	earrier			10a	184555
	b	If the carrier, service, or other organization incurr				100	101000
	D	retention of the contract or policy, other than repo				10b	
	Spe	cify nature of costs.	,	, I			1
_							
	art				-	-	
		d the insurance company fail to provide any inform		lete Schedule	A?	Yes	X No
12	If t	he answer to line 11 is "Yes," specify the informati	ion not provided.				

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

OMB No. 1210-0110

					nspection		
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024							•
A Name of plan ZETA ASSOCIATES INC	ORPORATE	D INDIVIDUAL BENEFIT ACCOU	UNT		digit umber (PI	N) •	501
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500	С	E mploye	er Identific	ation Number (I	EIN)
ZETA ASSOCIATES INC	ORPORATE	D		54-12	279046		
		erning Insurance Contract A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance cal		RTH AMERICA					
	(a) NAIC	(d) Contract or	(e) Approximate numb	ber of		Policy or co	ntract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at el policy or contract ye		(f)	From	(g) To
23-1503749	65498	OK965514			01/01/202	4	12/31/2024
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 (b) Total amount of fees paid							
		516					6
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all per	rsons).			
	(a) Name	and address of the agent, broker	r, or other person to whom o	commissio	ns or fees	were paid	
MCGRIFF INSURANCE SE	ERVICES, IN		BOX 896620 RLOTTE, NC 28289				
(b) Amount of sales an	nd hase	Fe	ees and other commissions	paid			
commissions pai		(c) Amount	(d)	Purpose			(e) Organization code
	516						3
	(a) Name	and address of the agent, broker	r. or other person to whom c	commissio	ns or fees	were paid	
MCGRIFF INSURANCE SE		C. 736 N	MARKET ST SUITE 1000 ITANOOG, TN 37402				
(b) Amount of sales an	nd base	Fe	ees and other commissions	paid			
commissions pai		(c) Amount	(d)	Purpose			(e) Organization code
		6					3

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Tops and other commissions noid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
commissions paid	· · · · · · · · · · · · · · · · · · ·		code				
(=) N =							
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base			Organization				
commissions paid	(c) Amount	(d) Purpose	code				
•							
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid					
			1				
		Fees and other commissions paid	(e)				
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization				
commissions paid	(c) Amount	(u) 1 dipose	code				
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Tops and other commissions noid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
commissions paid	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000				
(a) Nov	me and address of the agent broken	ar other nersen to whom commissions or feed were noid					
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base							
commissions paid	(c) Amount	(d) Purpose	Organization code				
•							

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

Pa	rt III Welfare Benefit Contract Information	on				
	If more than one contract covers the same gro the information may be combined for reporting					
	employees, the entire group of such individual	contracts with each carrier r	nay be	treated as a unit for po	urposes of t	his report.
8 E	Benefit and contract type (check all applicable boxes)					
í	a ☐ Health (other than dental or vision) b	Dental	С	Vision		d Life insurance
•	■ Temporary disability (accident and sickness) f	Long-term disability	a	Supplemental unem	oloyment	h Prescription drug
i	☐ Stop loss (large deductible) j	☐ HMO contract		PPO contract	,	I Indemnity contract
	======================================		٠. ٢	11 0 contract		I I Indominity contract
•	m X Other (specify) ► BACC FULLY INSURED, PAR	1. ACCIDENT				
0 F	'ynarianaa ratad aantraata.					
	xperience-rated contracts: Premiums: (1) Amount received	9a	(1)			_
	(2) Increase (decrease) in amount due but unpaid					_
	(3) Increase (decrease) in unearned premium reserv					
	(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)	
	b Benefit charges (1) Claims paid				1 3 3 (3)	
	(2) Increase (decrease) in claim reserves					
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
	c Remainder of premium: (1) Retention charges (on a	n accrual basis)				
	(A) Commissions	9c(⁻)(A)			
	(B) Administrative service or other fees	9c(′)(B)			
	(C) Other specific acquisition costs					
	(D) Other expenses					
	(E) Taxes					
	(F) Charges for risks or other contingencies					
	(G) Other retention charges				0-(4)(1)	
	(H) Total retention	_			9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These an				9c(2)	
	d Status of policyholder reserves at end of year: (1) A	·			9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
	Dividends or retroactive rate refunds due. (Do not in Nonexperience-rated contracts:	icidde amount entered in iin	90(2)	.)	9e	
	Total premiums or subscription charges paid to carr	er			10a	5161
	b If the carrier, service, or other organization incurred				100	0101
	retention of the contract or policy, other than reporte				10b	
5	Specify nature of costs.	, , , ,				
Pa	rt IV Provision of Information					
11	Did the insurance company fail to provide any information	on naccacany to complete Co			V	IV Na
	Did the insurance company fail to provide any information	on necessary to complete so	nedule	e A?	Yes	X No

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

OMB No. 1210-0110

					nspection		
For calendar plan year 202	24 or fiscal pl	an year beginning 01/01/2024		and end	ding 12/3	31/2024	•
A Name of plan ZETA ASSOCIATES INC	A Name of plan ZETA ASSOCIATES INCORPORATED INDIVIDUAL BENEFIT ACCOUNT				e-digit number (PI	N) •	501
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		D Employ	yer Identific	ation Number (I	EIN)
ZETA ASSOCIATES INC	ORPORATE	D		54-	1279046		
		erning Insurance Contrac A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance call LIFE INSURANCE COMPA		RTH AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nur	mber of		Policy or co	ntract year
(b) EIN	code	(d) Contract or identification number	persons covered at policy or contract		(f)	From	(g) To
23-1503749	65498	LK962754			01/01/202	24	12/31/2024
2 Insurance fee and comr descending order of the		mation. Enter the total fees and to	tal commissions paid. Lis	t in line 3 t	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		18908					1008
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all p	ersons).			
	(a) Name	and address of the agent, broker	, or other person to whom	commissi	ons or fees	were paid	
MCGRIFF INSURANCE SE	ERVICES, IN		BOX 896620 RLOTTE, NC 28289				
(b) Amount of sales an	d hase	Fe	es and other commissions	s paid			
commissions pai		(c) Amount	(0	d) Purpose)		(e) Organization code
	18908						
	(a) Name	and address of the agent, broker	or other person to whom	commissi	ons or fees	were paid	
MCGRIFF INSURANCE SE		C. 736 M	ARKET ST SUITE 1000 TANOOG, TN 37402		<u> </u>	wore para	
(b) Amount of sales an	d base	Fe	es and other commissions	s paid		_	
commissions pai		(c) Amount	(0	d) Purpose)		(e) Organization code
		1008					

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commissions paid	· · · · · · · · · · · · · · · · · · ·		code
(=) N =			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid	
			1
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) 1 dipose	code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commodicino para	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid	
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

Pa	art I	Welfare Benefit Contract Information	ation					
		If more than one contract covers the same						
		the information may be combined for repor employees, the entire group of such individ						r individual
8	Rone	fit and contract type (check all applicable boxes)		arror may be	arated do a drift for p	arpooco or t	ino roporti	
_	_	1		٦	Vision		d ☐ Life in	all range
	a _	Health (other than dental or vision)	b Dental	<u></u>				surance
	e _	Temporary disability (accident and sickness)	f X Long-term disabili		Supplemental unem	nployment	h Preso	_
	i	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indem	nity contract
	m 🔈	Other (specify) LTD FULLY INSURED BAS	SIC GROUP					
9 E	Ехре	rience-rated contracts:					_	
	a P	Premiums: (1) Amount received		9a(1)			_	
	((2) Increase (decrease) in amount due but unpai	d	9a(2)			_	
	((3) Increase (decrease) in unearned premium res	serve	9a(3)		1		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid					_	
		(2) Increase (decrease) in claim reserves				1 21 (2)		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	·	0.747/47			4	
		(A) Commissions		9c(1)(A)			4	
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			_	
		(C) Other specific acquisition costs		9c(1)(D)			\dashv	
		(D) Other expenses		9c(1)(E)			-	
		(E) Taxes(F) Charges for risks or other contingencies.					\dashv	
		(G) Other retention charges					\dashv	
		(H) Total retention				9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These					<u>'</u>	
		Status of policyholder reserves at end of year: (1	<u>—</u>			9c(2) 9d(1)		
		(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do n				9e		
10		nexperience-rated contracts:		<u></u>	.,			
_		Total premiums or subscription charges paid to o	carrier			10a		189084
	_	If the carrier, service, or other organization incur						
		retention of the contract or policy, other than rep				10b		
	Spec	cify nature of costs.						
Pa	rt l'	V Provision of Information						
		the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	Α?	Yes	X No	
		the insurance company rain to provide any informative answer to line 11 is "Yes," specify the informative		ioto Coricadio		1		
14	ii th	e answer to line it is ites, specify the informat	ion noi provided. 🔻					

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

OMB No. 1210-0110

n.mant to FDICA anotion 400(a)(0)					orm is Open to Public Inspection		
For calendar plan year 202	24 or fiscal pla	an year beginning 01/01/2024		and en	ding 12/31/2024	•	
A Name of plan ZETA ASSOCIATES INC	ORPORATE	D INDIVIDUAL BENEFIT ACCC	DUNT	B Three plan	e-digit number (PN)	501	
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		D Emplo	yer Identification Numb	er (FIN)	
·	ZETA ASSOCIATES INCORPORATED 54-1279046						
	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 car CIGNA HEALTH AND LIFE		EE COMPANY					
/L) FIN	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy o	r contract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To	
59-1031071	67369	02180C	68	68 12/01/2023		11/30/2024	
	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 (b) Total amount of fees paid							
	38970 0						
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees were paid		
MCGRIFF, A MARSH & M	CLENNAN A		OCHEROKEE AVE #300 XANDRIA, VA 22312				
(b) Amount of sales an	id base	F	ees and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpose	9	(e) Organization code	
	38970					3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees were paid		
		•			·		
(b) Amount of sales an	nd hase	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose		(e) Organization code	

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commissions paid	· · · · · · · · · · · · · · · · · · ·		code
(=) N =			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid	
			1
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) 1 dipose	code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commodicino para	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid	
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

Pa	rt l	III	Welfare Benefit Contract Informal If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	group of employees of the ng purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cov	
8	2 on	ofit o	nd contract type (check all applicable boxes)	iai contracts with each ca	aniei may be	treated as a utilit for p	urposes or t	ins report.	
	г	_		h V Darta	• V	A . G		ا من □ ند. :	
•	a [ealth (other than dental or vision)	b X Dental		Vision			nsurance
(е	Те	emporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prese	cription drug
	i [Sto	op loss (large deductible)	j HMO contract	k	PPO contract		I Inder	nnity contract
	m	Ot	her (specify)						
	_								
9 E	хре	erien	ce-rated contracts:						
;	a i	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid		9a(2)				
		(E)	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	Earned ((1) + (2) - (3))				. 9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(E)	ncurred claims (add (1) and (2))				9b(3)		
		(4) C	Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (o	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(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))	
		(2) [Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)	9c(2)		
	d	Stat	us 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)		
	е	Divi	dends or retroactive rate refunds due. (Do no	t include amount entered	l in line 9c(2)	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to c	arrier			10a		357715
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
	_		ntion of the contract or policy, other than repo	rted in Part I, line 2 abov	e, report amo	ount	10b		
	she.	City i	nature of costs.						
Pa	rt I	W	Provision of Information						
							V	V N-	
			insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No	
12	If t	he ar	nswer to line 11 is "Yes," specify the informati	on not provided.					

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

OMB No. 1210-0110

					nspection		
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024					•		
A Name of plan ZETA ASSOCIATES INC	ORPORATE	D INDIVIDUAL BENEFIT ACCO	UNT	B Three plan	e-digit number (Pl	N) •	501
C Plan sponsor's name a	s shown on lii	ne 2a of Form 5500		D Emplo	yer Identific	ation Number (I	EIN)
ZETA ASSOCIATES INC	ORPORATE			54-	1279046		
	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 car CIGNA HEALTH AND LIFE		E COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
51-0104167	62634	02180C	68		12/01/202	23	11/30/2024
	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 (b) Total amount of fees paid							
		5025					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF, A MARSH & MO	CLENNAN AC		CHEROKEE AVE #300 XANDRIA, VA 22312				
(b) Amount of sales an	d hase	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	5025					3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid	
(b) Amount of sales an	d base	F	ees and other commission	ns paid			
		(c) Amount	(d) Purpose			(e) Organization code	

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commissions paid	· · · · · · · · · · · · · · · · · · ·		code
(=) N =			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid	
			1
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) 1 dipose	code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commissions paid	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid	
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

Pa	rt III	Welfare Benefit Contract Informa	ation					
		If more than one contract covers the same the information may be combined for report						
		employees, the entire group of such individ	ual contracts with each c	arrier may be	treated as a unit for p	urposes of t	his report.	
8 E	Benefit	and contract type (check all applicable boxes)						
;	a	Health (other than dental or vision)	b Dental	С	Vision		d X Life i	nsurance
(e	Temporary disability (accident and sickness)	f X Long-term disabili	ity g	Supplemental unem	ployment	h Pres	cription drug
i	i∏s	Stop loss (large deductible)	j HMO contract	- <u>-</u>	PPO contract		I Inde	mnity contract
ļ	m 🛚	Other (specify) AD&D	_		•		_	
9 E	Experie	nce-rated contracts:						
6	a Pre	miums: (1) Amount received		9a(1)				
	(2)	Increase (decrease) in amount due but unpaid	t	9a(2)			_	
		Increase (decrease) in unearned premium res		9a(3)		T = 2.5		
	_ ' '	Earned ((1) + (2) - (3))				9a(4)		
		enefit charges (1) Claims paid					_	
	٠,	Increase (decrease) in claim reserves				21.42		
	(3)	Incurred claims (add (1) and (2))				9b(3)		
	٠,	Claims charged				9b(4)		
	C Re	emainder of premium: (1) Retention charges (c	•	0 (1)(1)			4	
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		9c(1)(B)			_	
		(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 . (G) Other retention charges					-	
						9c(1)(H)		
	(2)	(H) Total retention					'	
) Dividends or retroactive rate refunds. (These	_			9c(2)		
		atus of policyholder reserves at end of year: (1				9d(1)		
	•) Claim reserves				9d(2)		
	•) Other reservesvidends due. (Do n				9d(3) 9e		
10		xperience-rated contracts:	or include amount entere	u III IIIIe 90(2) .	.)	36		
		otal premiums or subscription charges paid to o	rarrier			10a		50247
						100		00247
		the carrier, service, or other organization incur tention of the contract or policy, other than rep				10b		
;		nature of costs.		, -				-
Pa	rt IV	Provision of Information						
11	Did th	e insurance company fail to provide any inform	nation necessary to comp	lete Schedule	A?	Yes	X No	
		answer to line 11 is "Yes," specify the informat						

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

OMB No. 1210-0110

					nspection		
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024					•		
A Name of plan ZETA ASSOCIATES INC	ORPORATE	D INDIVIDUAL BENEFIT ACCO	UNT		e-digit number (Pl	N) •	501
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		D Emplo	yer Identific	ation Number (I	EIN)
ZETA ASSOCIATES INC	ZETA ASSOCIATES INCORPORATED 54-1279046						
	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 car AMERICAN HERITAGE LI		ICE COMPANY					
	(a) NIAIC	(d) Combract on	(e) Approximate n	umber of		Policy or co	ntract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	at end of	(f)	From	(g) To
59-0781901	60534	59-0781901	20998		01/01/202	24	12/31/2024
	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 (b) Total amount of fees paid							
		9					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
		and address of the agent, broke			ions or fees	were paid	
MCGRIFF INSURANCE SE	ERVICES, IN		AIRPORT CENTER DR ENSBORO, NC 27409	#1800			
(b) Amount of sales an	d hase	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
9						3	
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales an	d base	F	ees and other commissio	ns paid			
		(c) Amount	(d) Purpose			(e) Organization code	

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commissions paid	· · · · · · · · · · · · · · · · · · ·		code
(=) N =			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid	
			1
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) 1 dipose	code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commissions paid	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000
(a) Nov	me and address of the agent broken	ar other nersen to whom commissions or feed were noid	
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

P	art	III	Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of thing purposes if such conf	racts are expe	érience-rated as a uni	it. Where co	ntracts	cover individual
8	Ren	efit a	nd contract type (check all applicable boxes)	dar contracto with cach c	arrior may be	arated do a drift for p	u.pecce c. t.	по гор	<u></u>
•	г	_	ealth (other than dental or vision)	h Dontal	٦	Vision		d∏ı	Life insurance
	a [=		b Dental				브	
	e [f Long-term disabili		Supplemental unem	ployment		Prescription drug
	i	St	op loss (large deductible)	j HMO contract	k 📗	PPO contract		IПI	ndemnity contract
	m	X O	her (specify) ACCIDENT						
9	Ехре	erien	ce-rated contracts:						
	a I	Prem	iums: (1) Amount received		9a(1)			_	
		(2) lı	ncrease (decrease) in amount due but unpaid					_	
			ncrease (decrease) in unearned premium res						
	_		Earned ((1) + (2) - (3))				9a(4)		
	b		efit charges (1) Claims paid		· · · · ·			_	
		. ,	ncrease (decrease) in claim reserves				21 (2)		
		` '	ncurred claims (add (1) and (2))				9b(3)		
		` '	Claims charged				9b(4)		
	С		nainder of premium: (1) Retention charges (o	·	0-(4)(4)			_	
			(A) Commissions		9c(1)(A)			_	
			(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			_	
			(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)			-	
			(E) Taxes(E)		9c(1)(E)			_	
			(F) Charges for risks or other contingencies.		9c(1)(F)			-	
			(G) Other retention charges					_	
			(H) Total retention				9c(1)(H)		
			Dividends or retroactive rate refunds. (These	_	_		9c(2)		
	d		us of policyholder reserves at end of year: (1		_		9d(1)		
	u		Claim reserves	•			9d(2)		
		. ,	Other reserves				9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do no				9e		
10	No		erience-rated contracts:			,			
	а	Tota	al premiums or subscription charges paid to c	arrier			10a		94
	b	If th	e carrier, service, or other organization incurr	ed any specific costs in o	connection with	h the acquisition or			
			ntion of the contract or policy, other than repo				10b		
	Spe	cify r	nature of costs.						
P	art l	IV	Provision of Information						
			insurance company fail to provide any inform	ation necessary to comp	lete Schodula	Δ2 Π	Yes	X No	
					iete Schedule	Α:	169	/\ INO	
12	if t	ne ar	nswer to line 11 is "Yes," specify the informati	on not provided. 🕨					

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

2024

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)				Inspection
For calendar plan year 202	24 or fiscal plar	n year beginning 01/01/2024		and en	ding 12/	31/2024	
A Name of plan ZETA ASSOCIATES INC	ORPORATED	INDIVIDUAL BENEFIT ACCO	UNT	B Three	e-digit number (Pl	\ \ \ \	501
				pian	number (r	,	
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	ver Identific	cation Number (EIN)
ZETA ASSOCIATES INC	ORPORATED			54-	1279046	·	,
		ning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		CE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
59-0781901	60534	22259	238		01/01/202	24	12/31/2024
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		9558					0
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF INSURANCE SI	ERVICES, INC		AIRPORT CENTER DR ENSBORO, NC 27409	#1800			
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	8431						3
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
THE BENEFIT COMPANY	INC		BOX 211486 UMBIA, SC 29221				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code
	1127						3
				_			

(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commissions paid	· · · · · · · · · · · · · · · · · · ·		code
(=) N =			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rees were paid	
			1
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) 1 dipose	code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Tops and other commissions noid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
commodicino para	· · ·	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0000
(a) Nov	me and address of the agent broken	ar other nersen to when commissions or feed were noid	
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
•			

F	art	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m		s a unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		. 6b	
	С	Premiums due but unpaid at the end of the year		. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)	•		
		(o) [] other (speedily)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
	-	, , , ,			

P	art	If mor	fare Benefit Contract Informate than one contract covers the same formation may be combined for report	group of employees of th ing purposes if such con	tracts are expe	érience-rated as a un	it. Where co	ntracts	cover individual
			byees, the entire group of such individ	uai contracts with each c	arrier may be	treated as a unit for p	urposes of the	nis repo	π.
8	г	_	tract type (check all applicable boxes)			l			
	a	∐ Health (oʻ =	ther than dental or vision)	b Dental	_	Vision			ife insurance
	е	Tempora	ry disability (accident and sickness)	f Long-term disabil	ty g	Supplemental unem	ployment	h ∐ P	rescription drug
	i	Stop loss	(large deductible)	j HMO contract	k 🗌	PPO contract		I In	ndemnity contract
	m	Other (sp	pecify) ACCIDENT						
		_							
9	Ехрє	rience-rate	d contracts:						
	a I	Premiums: (1) Amount received		9a(1)				
		(2) Increase	e (decrease) in amount due but unpai	l	9a(2)				
			e (decrease) in unearned premium res				Т		
		(4) Earned	((1) + (2) - (3))				. 9a(4)		
	b		arges (1) Claims paid		· · ·			_	
		• ,	e (decrease) in claim reserves						
			l claims (add (1) and (2))				9b(3)		
		` '	charged				9b(4)		
	С		of premium: (1) Retention charges (c	•	0.(4)(4)			_	
		` '	nmissions		9c(1)(A)			_	
			ministrative service or other fees		9c(1)(B) 9c(1)(C)			_	
			ner specific acquisition costs		9c(1)(D)			_	
		` '	er expenses		9c(1)(E)			_	
		` '	resarges for risks or other contingencies .		9c(1)(F)			4	
			ner retention charges					_	
			al retention				9c(1)(H)		
		` '	ds or retroactive rate refunds. (These	_	_		9c(2)		
	d		olicyholder reserves at end of year: (1				9d(1)		
	<u>~</u>	•	eserves				9d(2)		
		` '	eserves				9d(3)		
	е	` '	or retroactive rate refunds due. (Do n				9e		
10	No		e-rated contracts:			•	•		
	а	Total prem	iums or subscription charges paid to o	arrier			10a		71145
	b	If the carrie	er, service, or other organization incur	ed any specific costs in o	connection witl	h the acquisition or			
	_		f the contract or policy, other than rep	orted in Part I, line 2 abov	/e, report amo	unt	10b		
	Spe	cify nature o	of costs.						
D	0 KT	V Dro	vision of Information						
	art l								
			nce company fail to provide any inform		lete Schedule	A?	Yes	X No	
12	If t	ne answer to	o line 11 is "Yes," specify the informat	on not provided.					

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation **Service Provider 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.

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024	and ending 12/31/2024	
A Name of plan	B Three-digit	
ZETA ASSOCIATES INCORPORATED INDIVIDUAL BENEFIT ACCOUNT		501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
ZETA ASSOCIATES INCORPORATED	54-1279046	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information requ\$5,000 or more in total compensation (i.e., money or anything else of monetary value) in conn position with the plan during the plan year. If a person received only eligible indirect compens you are required to answer line 1 but are not required to include that person when completing	ection with services rendered to the plan of sation for which the plan received the requithe remainder of this Part.	or the person's
Information on Persons Receiving Only Eligible Indirect Compensatio		
Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this indirect compensation for which the plan received the required disclosures (see instructions fo		Yes 🛚
No	definitions and conditions)	les M
If you answered line 1a "Yes," enter the name and EIN or address of each person providing the received only eligible indirect compensation. Complete as many entries as needed (see instru	ctions).	viders who
(b) Enter name and EIN or address of person who provided you disclos	ures on eligible indirect compensation	
(b) Enter name and EIN or address of person who provided you disclos	ures on eligible indirect compensation	
(a) Lines have and Lines a database of person who promote you disease	aree on engine maneer compensation	
(b) Enter name and EIN or address of person who provided you disclos	ures on eligible indirect compensation	
(a) Liner hame and Lines a dad see of person who promote you diserse	aree on origina maneer compensation	
(b) Enter name and EIN or address of person who provided you disclos	ures on eligible indirect compensation	
(w) Enter frame and Environ address of person who provided you disclos	ures on engine munect compensation	

Schedule C (For	m 5500) 2024	Page 2- 1
(t	Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
·		
(k	Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(k	Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(1) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(k	Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
	1) Enter name and EIN or address of parson who provided you	u displactures on cligible indirect componention
	Enter name and EIN or address of person who provided you	d disclosures on eligible indirect compensation
(k	Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(1	Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
	, Elic. Hamo and Elit of address of polson who provided you	a dississation of original marrow comportation

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answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN o	r address (see instructions)		
CIGNA HI	EALTH & LIFE INSUR	ANCE CO				
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 38 50 13 49 56 31 62	PROVIDES CLAIM & SERVICES	0	Yes 🛛 No 🗌	Yes X No [0	Yes X No
			(a) Enter name and FIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Part I	Service Provider	Information	(continued
Part I	Service Provider	information	(continue

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensor provides contract administrator, consulting, custodial, investment advisory, investment management.			
questions for (a) each source from whom the service provider received \$1,000 or more in in- provider gave you a formula used to determine the indirect compensation instead of an amo many entries as needed to report the required information for each source.	direct compensation and (b) each s	ource for whom the service	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
	(2) 5		
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.		

Part II Service Providers Who Fail or Refus	se to Provide Inforr	mation		
4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.				
(a) Enter name and EIN or address of service provider (instructions)	(see (b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (instructions)	(see (b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (instructions)	(see (b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (instructions)	(see (b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (instructions)	(see (b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)		
а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
Ex	xplanation:	
	Manage	h ru
<u>a</u>	Name:	b EIN:
<u>c</u> d	Position: Address:	A Tolonhono:
u	Address.	e Telephone:
Ex	xplanation:	
	•	
а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
		·
Explanation:		
		1.
<u>a</u>	Name:	b EIN:
C	Position:	2711
d	Address:	e Telephone:
Fx	xplanation:	
	,p.a.a	
а	Name:	b EIN:
C	Position:	
d	Address:	e Telephone:
-		
Explanation:		