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.

2016
This Form is Open to Public Inspection

Part I  Annual Report Identification Information
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A This return/report is for:
☐ a multiemployer plan
☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
☒ a single-employer plan
☐ a DFE (specify) ________________

B This return/report is:
☐ the first return/report
☐ the final return/report
☐ an amended return/report
☐ a short plan year return/report (less than 12 months)

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

D Check box if filing under:
☐ Form 5558
☐ automatic extension
☐ the DFVC program
☐ special extension (enter description)

Part II  Basic Plan Information—enter all requested information

1a Name of plan
LOCKHEED MARTIN BUSINESS TRAVEL ACCIDENT INSURANCE

1b Three-digit plan number (PN) 504

1c Effective date of plan 07/01/1974

2a Plan sponsor’s name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
LOCKHEED MARTIN CORPORATION

6801 ROCKLEDGE DRIVE, CCT-115
BETHESDA, MD 20817

2b Employer Identification Number (EIN) 52-1893632

2c Plan Sponsor’s telephone number 863-647-0370

2d Business code (see instructions) 339900

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. 06/21/2017 ROBERT MUENINGHOFF

Signature of plan administrator Date Enter name of individual signing as plan administrator

SIGN HERE
Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor

SIGN HERE
Signature of DFE Date Enter name of individual signing as DFE

Preparer’s name (including firm name, if applicable) and address (include room or suite number)
Preparer’s telephone number

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.
### Plan administrator's name and address

**3a** Plan administrator's name and address  
- **A** Same as Plan Sponsor

**3b** Administrator's EIN

**3c** Administrator's telephone number

**3d** Sponsor's name

**3e** EIN and the plan number from the last return/report:

#### DK

**4** If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

**4a** Sponsor's name

**4b** EIN

**4c** PN

**4d** Sponsor's telephone number

#### 5

**5** Total number of participants at the beginning of the plan year

**5a** Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c, and 6d**):

**6a(1)** Total number of active participants at the beginning of the plan year

**6a(2)** Total number of active participants at the end of the plan year

**6b** Retired or separated participants receiving benefits

**6c** Other retired or separated participants entitled to future benefits

**6d** Subtotal. Add lines **6a(2), 6b, and 6c**

**6e** Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

**6f** Total. Add lines **6d and 6e**

**6g** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

**6h** Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

**7** Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)

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

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

#### 9

**9a** Plan funding arrangement (check all that apply)

(1) __ Insurance

(2) __ Code section 412(e)(3) insurance contracts

(3) __ Trust

(4) __ General assets of the sponsor

**9b** Plan benefit arrangement (check all that apply)

(1) __ Insurance

(2) __ Code section 412(e)(3) insurance contracts

(3) __ Trust

(4) __ General assets of the sponsor

#### 10

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

**a** Pension Schedules

(1) __ R (Retirement Plan Information)

(2) __ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) __ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

**b** General Schedules

(1) __ H (Financial Information)

(2) __ I (Financial Information – Small Plan)

(3) __ A (Insurance Information)

(4) __ C (Service Provider Information)

(5) __ D (DFE/Participating Plan Information)

(6) __ G (Financial Transaction Schedules)
### Part III  
**Form M-1 Compliance Information (to be completed by welfare benefit plans)**

**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) 

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>☒</td>
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If “Yes” is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)

<table>
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**11c** Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code ___________________________
### SCHEDULE A (Form 5500)

#### Department of the Treasury
- Internal Revenue Service
- Department of Labor
- Employee Benefits Security Administration
- Pension Benefit Guaranty Corporation

#### Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).
- File as an attachment to Form 5500.
- Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110  
2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

<table>
<thead>
<tr>
<th>A Name of plan</th>
<th>B Three-digit plan number (PN)</th>
<th>C Plan sponsor’s name as shown on line 2a of Form 5500</th>
<th>D Employer Identification Number (EIN)</th>
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<tbody>
<tr>
<td>LOCKHEED MARTIN BUSINESS TRAVEL ACCIDENT INSURANCE</td>
<td>504</td>
<td>LOCKHEED MARTIN CORPORATION</td>
<td>52-1893632</td>
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#### Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

   (a) Name of insurance carrier
   
   PRUDENTIAL INSURANCE COMPANY OF AMERICA

   (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |
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<tr>
<td>22-1211670</td>
<td>68241</td>
<td>43406-1</td>
<td>79054</td>
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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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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<tr>
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### Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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<tr>
<td>4</td>
<td>Current value of plan’s interest under this contract in the general account at year end</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Current value of plan’s interest under this contract in separate accounts at year end</td>
<td>5</td>
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</tbody>
</table>

#### 6 Contracts With Allocated Funds:

- **a** State the basis of premium rates

- **b** Premiums paid to carrier

- **c** Premiums due but unpaid at the end of the year

- **d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs

- **e** Type of contract: (1) [ ] individual policies (2) [ ] group deferred annuity (3) [ ] other (specify)

- **f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here [ ]

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

- **a** Type of contract: (1) [ ] deposit administration (2) [ ] immediate participation guarantee (3) [ ] guaranteed investment (4) [ ] other

- **b** Balance at the end of the previous year

- **c** Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below)

- **d** Total of balance and additions (add lines 7b and 7c(6))

- **e** Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below)

- **f** Balance at the end of the current year (subtract line 7e(5) from line 7d)
### Part III  Welfare Benefit Contract Information

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

#### 8 Benefit and contract type (check all applicable boxes)

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<tr>
<td>a</td>
<td>Health (other than dental or vision)</td>
<td>b</td>
<td>Dental</td>
<td>c</td>
</tr>
<tr>
<td>e</td>
<td>Temporary disability (accident and sickness)</td>
<td>f</td>
<td>Long-term disability</td>
<td>g</td>
</tr>
<tr>
<td>i</td>
<td>Stop loss (large deductible)</td>
<td>j</td>
<td>HMO contract</td>
<td>k</td>
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<tr>
<td>m</td>
<td>Other (specify)</td>
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#### 9 Experience-rated contracts:

##### a Premiums:

- (1) Amount received .................................................. 9a(1)
- (2) Increase (decrease) in amount due but not paid .................... 9a(2)
- (3) Increase (decrease) in unearned premium reserve .................. 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)

##### c 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 ................................................................. 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 benefits after retirement .............. 9d(1)
- (2) Claim reserves ..................................................... 9d(2)
- (3) Other reserves ..................................................... 9d(3)

##### e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) ................ 9e

#### 10 Noneexperience-rated contracts:

##### a Total premiums or subscription charges paid to carrier ................................................................. 10a

##### b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ................................................ ........................................ 10b

Specify nature of costs.

### Part IV  Provision of Information

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

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