Form 5500	•	t of Employee Benefit Plan		OMB Nos. 12 12	10-0110
Department of the Treasury Internal Revenue Service	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).			2021	
Department of Labor Complete all entries in accordance with Employee Benefits Security the instructions to the Form 5500.					
Pension Benefit Guaranty Corporation			This	Form is Open to Pu Inspection	ıblic
Part I Annual Report Id	entification Information				
For calendar plan year 2021 or fisca	al plan year beginning 01/01/2021	and ending 12/31/20)21		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in accord			ns.)
	X 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	2 months)		
C If the plan is a collectively-barga	ined plan, check here		. •		
D Check box if filing under:	Form 5558	automatic extension	the	e DFVC program	
	special extension (enter description)			
E If this is a retroactively adopted p		201, check here	•		
	nation—enter all requested informatior				
1a Name of plan			1b	Three-digit plan	
ZETA ASSOCIATES INCORPOR	ATED INDIVIDUAL BENEFIT ACCOUN	т		number (PN) 🕨	501
			1c	Effective date of pla 06/01/1984	an
2a Plan sponsor's name (employe Mailing address (include room, City or town, state or province,	2b Employer Identification Number (EIN) 54-1279046				
ZETA ASSOCIATES INCORPORA	(TED		2c	Plan Sponsor's tele number 703-385-7050	ephone
10302 EATON PLACE SUITE 500 FAIRFAX, VA 22030			2d	Business code (see instructions) 541700	9

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	Filed with authorized/valid electronic signature.	05/03/2022	SUE SUK
HERE		Date	Enter name of individual signing as plan administrator
SIGN	Filed with authorized/valid electronic signature.	05/03/2022	SUE SUK
HERE		Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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Ba	Form 5500 (2021) Page 2 Plan administrator's name and address X Same as Plan Sponsor	3b Ad	ministrator's EIN
		3c Ad	ministrator's telephone mber
	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	4b EI	N
a c	Sponsor's name Plan Name	4d PN	I
;	Total number of participants at the beginning of the plan year	5	27
;	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).		
a	(1) Total number of active participants at the beginning of the plan year	6a(1)	27
a((2) Total number of active participants at the end of the plan year	6a(2)	28
b	Retired or separated participants receiving benefits	6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	28
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f	Total. Add lines 6d and 6e	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
,	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		

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

4A 4B 4D 4E 4F 4H 4I 4L

9a	Plan fu	nding	arrangement (check all that apply)	9b	Plan b	penefit	arrangement (check all that apply)
	(1)		Insurance		(1)	X	Insurance
	(2)	Π	Code section 412(e)(3) insurance contracts		(2)	\square	Code section 412(e)(3) insurance contracts
	(3)	Π	Trust		(3)		Trust
	(4)	X	General assets of the sponsor		(4)	X	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)						
а	Pensio	on Scl	nedules	b	Gene	ral Scl	hedules
	(1)		R (Retirement Plan Information)		(1)		H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)		I (Financial Information – Small Plan)
	(-)		Purchase Plan Actuarial Information) - signed by the plan		(3)	X	6 (Insurance Information)
			actuary		(4)	×	C (Service Provider Information)
	(3)		SB (Single-Employer Defined Benefit Plan Actuarial		(5)		D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)

Page 3

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
2520.1	olan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 01-2.)
11b Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
Receip	the Receipt Confirmation Code for the 2021 Form M-1 annual report. If the plan was not required to file the 2021 Form M-1 annual report, enter the ot 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 of Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE		Incura	nce Informatio	<u> </u>			
(Form 5500		insurai	nce mormation			OM	B No. 1210-0110
Department of the Trea	sury		schedule is required to be filed under section 104 of the				
Department of Labor			Income Security Act of 19		.).		2021
Employee Benefits Security Ac	Iministration		attachment to Form 55				
Pension Benefit Guaranty Co		pursuant to	s are required to provide t ERISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and er	nding 12/3	31/2021	1
A Name of plan ZETA ASSOCIATES INC	ORPORATED	INDIVIDUAL BENEFIT ACCO	UNT		e-digit number (Pl	N) 🕨	501
				_			
C Plan sponsor's name a		e 2a of Form 5500		-	•	ation Number (EIN)
ZETA ASSOCIATES INC	ORPORATED			54-	1279046		
		ning Insurance Contract. Individual contracts grouped					
1 Coverage Information:		- ·					
(a) Name of insurance ca CIGNA HEALTH AND LIF		COMPANY AND AFFILIATES	;				
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
59-1031071	67369	3334243	713	713 01/01/202		1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	ther persons in
(a) Total	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
		234156					4064
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF INSURANCE S	ERVICES, INC.		RLOTTE RLOTTE, NC 27214				
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code
234156 4064		4064	SERVICE/GEN. AGENT	FEES			3
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	

			/=
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(b) Amount of sales and base	F		

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Page **2 –** 1

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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
			1

Schedule A (Form 5500) 2021

Page 3

	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	vidual contracts with each carrier ma	y be treated as a	unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end	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 co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify) •	d annuity		
	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	aintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) dther	•		
	h	Delence at the and of the province year		7b	
	b C	Balance at the end of the previous year	7c(1)	70	
	C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
			10(3)		
		•			
		(6)Total additions		7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	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)		
		•			
		(E) Total doductions		7e(5)	0
	f	(5) Total deductions		7e(5)	0

Ρ	Part	III Welfare Benefit Contract Informa	tion				
		If more than one contract covers the same g					
		the information may be combined for reporti employees, the entire group of such individu					
8	Bon	hefit and contract type (check all applicable boxes)	ai contracts with	each camer may be	e treated as a unit for pr		
Ŭ	F		b X Dental	e l	Vicion	a	
		X Health (other than dental or vision)			X Vision	d	Life insurance
	е	Temporary disability (accident and sickness)	f Long-term		Supplemental unem	oloyment h	X Prescription drug
	i	Stop loss (large deductible)	j HMO cont	ract k	PPO contract	I	X Indemnity contract
	m	Other (specify)					
9	Expe	erience-rated contracts:			I		
	а	Premiums: (1) Amount received				3742753	
		(2) Increase (decrease) in amount due but unpaid				6395	
		(3) Increase (decrease) in unearned premium rese					
	-	(4) Earned ((1) + (2) - (3))			1	9a(4)	3749148
	b	Benefit charges (1) Claims paid				3505673	
		(2) Increase (decrease) in claim reserves				72030	
		(3) Incurred claims (add (1) and (2))				9b(3)	3577703
		(4) Claims charged				9b(4)	3577703
	С	Remainder of premium: (1) Retention charges (or			1		
		(A) Commissions				149966	
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs					
		(D) Other expenses		$\Delta = (A) (E)$		307618	
		(E) Taxes				85461	
		(F) Charges for risks or other contingencies					
		(G) Other retention charges					E 400.45
		(H) Total retention				9c(1)(H)	543045
		(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)	526818
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount	entered in line 9c(2) .)	9e	
10) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	1744334
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo				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	X No	
12 If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A (Form 5500)			Insuranc	ce Information	n		ON	/IB No. 1210-0110
Department of the Treasury This schedule is requ				red to be filed under section 104 of the Income Security Act of 1974 (ERISA).				2021
	epartment of Labor enefits Security Ad		File as an a	ttachment to Form 55	00.			
Pension Be	enefit Guaranty Co	rporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar	[.] plan year 202	21 or fiscal plan	year beginning 01/01/2021		and er	ding 12/3	31/2021	-
A Name of ZETA ASSO		ORPORATED	INDIVIDUAL BENEFIT ACCOUN	іт		e-digit number (Pl	N) 🕨	501
C Plan spor	nsor's name a	s shown on line	e 2a of Form 5500		D Emplo	ver Identific	ation Number	(EIN)
•		ORPORATED				1279046		()
Part I			ning Insurance Contract . Individual contracts grouped as					
1 Coverage	Information:							
、 <i>′</i>	insurance ca	rrier ANY OF NORTH	H AMERICA					
(b) EIN (c) NAIC code		(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year			Policy or c	ontract year
		code	identification number			(f)	From	(g) To
23-1503749		65498	TD1960459	01/01/202		01/01/202	1	12/31/2021
	e fee and coming order of the		tion. Enter the total fees and tota	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	other persons in
	(a) Total a	amount of comm	nissions paid		(b) To	otal amount	of fees paid	
			21					7
3 Persons	receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
		(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
MCGRIFF IN	SURANCE SI	ERVICES, INC.		DX 896620 .OTTE, NC 28289				
(b) Amou	unt of sales ar	nd base	Fee	s and other commissio	ns paid			
	mmissions pai		(c) Amount		(d) Purpose			(e) Organization code
21 7			7					
		(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		(a) Name a						
		nd base	Foo	s and other commission	a paid			

(d) Purpose

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commissions paid

(c) Amount

(e) Organization code

Page **2 –** 1

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

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

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

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

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

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

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

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

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

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			1	

Schedule A (Form 5500) 2021

Page 3

	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	vidual contracts with each carrier ma	y be treated as a	unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end	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 co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify) •	d annuity		
	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	aintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) dther	•		
	h	Delence at the and of the province year		7b	
	b C	Balance at the end of the previous year	7c(1)	70	
	C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
			10(3)		
		•			
		(6)Total additions		7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	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)		
		•			
		(E) Total doductions		7e(5)	0
	f	(5) Total deductions		7e(5)	0

P	Part	I t	Welfare Benefit Contract Information of the same of the information may be combined for report employees, the entire group of such individed the same of the same	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover individua	
8	Ben	efit and	contract type (check all applicable boxes)						
	a	Hea	Ith (other than dental or vision)	b Dental	c	Vision		d Life insurance	
	еĪ	Tem	porary disability (accident and sickness)	f Long-term disabili	tv q	Supplemental unem	ployment	h Prescription dru	q
	i [loss (large deductible)	j HMO contract		PPO contract		I Indemnity contra	-
	• L		, <u> </u>		ĸL				101
	m	X Othe	er (specify) STATUTORY DISABILITY						
Q	Evn	arianca	-rated contracts:						
3			ms: (1) Amount received		9a(1)			-	
	ŭ		rease (decrease) in amount due but unpaid		9a(2)			-	
			rease (decrease) in unearned premium res		9a(3)			-	
		• •	rned ((1) + (2) - (3))				9a(4)		
	b	• •	it charges (1) Claims paid		9b(1)				
			rease (decrease) in claim reserves					-	
		• •	urred claims (add (1) and (2))				9b(3)		
		(4) Cla	ims charged				9b(4)		
	С	Rema	inder 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)				
) Charges for risks or other contingencies .		9c(1)(F)				
			b) Other retention charges				[
		``) Total retention				9c(1)(H))	
			vidends or retroactive rate refunds. (These				9c(2)		
	d		s of policyholder reserves at end of year: (1	, ,			9d(1)		
		(2) Cla	aim reserves				9d(2)		
		· · /	her reserves				9d(3)		
			ends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10			ience-rated contracts:						
	а		premiums or subscription charges paid to c				10a		207
	b		carrier, service, or other organization incurr ion of the contract or policy, other than repo				10b		

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

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

Provision of Information

Specify nature of costs.

Part IV

SCHEDULE A		Insurar	nce Information	n		OM	/B No. 1210-0110
(Form 5500)							
Department of the TreasuryThis schedule is required to be filed under section 104 of theInternal Revenue ServiceEmployee Retirement Income Security Act of 1974 (ERISA).						2021	
Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Co			are required to provide t		ion		
			ERISA section 103(a)(2)			This For	rm is Open to Public Inspection
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2					31/2021	1	
A Name of plan					e-digit		504
ZETA ASSOCIATES INC	ORPORATED	INDIVIDUAL BENEFIT ACCO	UNI	plan	number (Pl	N) 🕨	501
C Plan sponsor's name a	is shown on line	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
ZETA ASSOCIATES INC	ORPORATED			54-	1279046		
Part I Informat	ion Concer	ning Insurance Contrac	ct Coverage, Fees.	and Con	mission	s Provide info	rmation for each contract
		Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
LIFE INSURANCE COMP		HAMERICA					
		· · · ···					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year		(0)	,	ontract year
	code	identification number			(f) From		(g) To
23-1503749	65498	LK750914	01/0		01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	otal commissions paid. L	ist in line 3.	the agents,	brokers, and c	other persons in
(a) Total a	amount of comn	nissions paid		(b) Total amount of fees paid			
		11989					1723
3 Persons receiving com	missions and fe	es. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF INSURANCE S	ERVICES, INC.		BOX 896620 RLOTTE, NC 28289				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code
11989		1723					3
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
							T
	1	-	والمراجع والمتعالية والمتعالية والمتعار والمتعار	اما م م			

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

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Schedule A (Form 5500) 2021 v. 201209

Page **2 –** 1

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

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

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

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

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

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

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

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

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

	Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
			1		

Schedule A (Form 5500) 2021

Page 3

	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	vidual contracts with each carrier ma	y be treated as a	unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end	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 co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify) •	d annuity		
	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	aintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) dther	•		
	h	Delence at the and of the province year		7b	
	b C	Balance at the end of the previous year	7c(1)	70	
	C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
			10(3)		
		•			
		(6)Total additions		7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	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)		
		•			
		(E) Total doductions		7e(5)	0
	f	(5) Total deductions		7e(5)	0

P	Part	If mo the in	fare Benefit Contract Information one contract covers the same and formation may be combined for report loyees, the entire group of such individual	group of employees of the ing purposes if such contr	racts are exp	perience-rated as a unit	t. Where co	ontracts cover individual
8	Ben	efit and cor	ntract type (check all applicable boxes)					
	а	X Health (o	other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Tempora	ary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	ployment	h Prescription drug
	i [Stop loss	s (large deductible)	j 🗍 HMO contract	k	PPO contract		I Indemnity contract
	m	X Other (s	pecify) 🕨 SHORT-TERM DISABILITY		L	-		
9	Expe	erience-rate	ed contracts:					
	а	Premiums:	(1) Amount received		9a(1)			
		(2) Increas	e (decrease) in amount due but unpaid		9a(2)			
		(3) Increas	e (decrease) in unearned premium res	erve	9a(3)		T	
		(4) Earned	((1) + (2) - (3))	г			. 9a(4)	
	b	Benefit ch	arges (1) Claims paid		9b(1)			
		(2) Increas	e (decrease) in claim reserves		9b(2)		1	
		(3) Incurre	d claims (add (1) and (2))				9b(3)	
		()	charged				9b(4)	
	С		er of premium: (1) Retention charges (o	,		I		
		(A) Co	mmissions		9c(1)(A)			_
		(B) Ad	ministrative service or other fees		9c(1)(B)			_
		()	her specific acquisition costs		9c(1)(C)			_
		(D) Ot	her expenses		9c(1)(D)			_
		(E) Ta	xes		9c(1)(E)			
		. ,	arges for risks or other contingencies		9c(1)(F)			_
		. ,	her retention charges	•	9c(1)(G)		0.4040	
		()	tal retention	_			9c(1)(H))
			nds or retroactive rate refunds. (These				9c(2)	
	d		policyholder reserves at end of year: (1				9d(1)	
		(2) Claim	reserves				9d(2)	
		(3) Other I	reserves				9d(3)	
	е		or retroactive rate refunds due. (Do no	ot include amount entered	l in line 9c(2)] .)	9e	
10) No		e-rated contracts:				r	
	а	Total prem	niums or subscription charges paid to c	arrier			10a	119886
	b Spe	 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. Specify nature of costs. 						

11 Did the insurance company fail to provide any information necessary to complete Schedule A?

Yes X No

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

Provision of Information

Part IV

SCHEDULE (Form 5500		Insurance Information				OMB No. 1210-0110	
Department of the Treasury Internal Revenue Service This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2021				
Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Co	rporation	Insurance companies pursuant to	are required to provide t ERISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2					31/2021		
A Name of plan ZETA ASSOCIATES INC	ORPORATED I	INDIVIDUAL BENEFIT ACCOU	INT	B Thre	e-digit number (Pl	N) ►	501
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		-	•	ation Number ((EIN)
ZETA ASSOCIATES INC	ORPORATED			54-	1279046		
		ning Insurance Contrac					
1 Coverage Information:		÷ :					
(a) Name of insurance ca		H AMERICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year			,	ontract year
	code	identification number			(f) From		(g) To
23-1503749 65498		FLX963886			01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid		(b) Total amount of fees paid			
		16705					2785
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name ar	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF INSURANCE SI	ERVICES, INC.		3OX 896620 LOTTE, NC 28289				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code
16705 2785							
	(a) Name ar	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
			es and other commission				

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

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Page **2 –** 1

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

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

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

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

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

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

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

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

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

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			1	

Schedule A (Form 5500) 2021

Page 3

	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	vidual contracts with each carrier ma	y be treated as a	unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	4		
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end	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 co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify) •	d annuity		
	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	aintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) dther	•		
	h	Delence at the and of the province year		7b	
	b C	Balance at the end of the previous year	7c(1)	70	
	C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
			10(3)		
		•			
		(6)Total additions		7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	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)		
		•			
		(E) Total doductions		7e(5)	0
	f	(5) Total deductions		7e(5)	0

	Part	If more than one contract covers the same g the information may be combined for reportin employees, the entire group of such individu	roup of employees of the ng purposes if such conti	racts are exp	perience-rated as a unit	. Where co	ontracts cover individual	
8	Ben	nefit and contract type (check all applicable boxes)		_	_			
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f 🗌 Long-term disabilit	ty g	Supplemental unem	ployment	h Prescription drug	
	i [Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Exp	erience-rated contracts:			-			
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)		1		
		(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 (or	,		1		_	
		(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				9c(2)	_	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits afte	r retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)	_	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line 9c(2)) .)	9e		_
10) No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	arrier			10a	1670	51
	b Spe	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo ecify nature of costs.	<i>,</i> ,			10b		

P	art 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.				

SCHEDULE	Α	Insuran	ce Information	n		ON	//B No. 1210-0110
(Form 5500)						
	Department of the TreasuryThis schedule is required to be filed under section 104 of theInternal Revenue ServiceEmployee Retirement Income Security Act of 1974 (ERISA).				2021		
Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Co		 Insurance companies 			ion		
			ERISA section 103(a)(2)			This Foi	rm is Open to Public Inspection
For calendar plan year 20	21 or fiscal plan	year beginning 01/01/2021		and er	iding 12/3	1/2021	-
A Name of plan					e-digit		504
ZETA ASSOCIATES INC	ORPORATED	INDIVIDUAL BENEFIT ACCOU	JNT	plan	number (Pl	N) 🕨	501
C Plan sponsor's name a	is shown on line	e 2a of Form 5500		D Emplo	oyer Identific	ation Number	(EIN)
ZETA ASSOCIATES INC	ORPORATED			54-	1279046		
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage Fees	and Con	nmission	S Provide info	rmation for each contract
		. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrior						
LIFE INSURANCE COMP							
(b) EIN	(c) NAIC	(d) Contract or		(e) Approximate number of persons covered at end of		Policy or c	ontract year
	code	identification number	-	policy or contract year		From	(g) To
23-1503749	65498	OK965514			01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
	amount of comn	nissions paid		(b) To	otal amount	of fees paid	
		528				•	95
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
g		nd address of the agent, broker	•		ions or fees	were paid	
MCGRIFF INSURANCE SI	ERVICES, INC.		BOX 896620 RLOTTE, NC 28289				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
528		95					
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
						·	
		Er	os and other commission	ne naid			

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

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Page **2 –** 1

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

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

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

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

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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
			1

Schedule A (Form 5500) 2021

Page 3

	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	vidual contracts with each carrier ma	y be treated as a	unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end	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 co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify) •	d annuity		
	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	aintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) dther	•		
	h	Delence at the and of the province year		7b	
	b C	Balance at the end of the previous year	7c(1)	70	
	C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(3) Interest credited during the year	7c(4)		
		(4) Transferred from separate account	7c(5)		
			10(3)		
		•			
		(6)Total additions		7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	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)		
		•			
		(E) Total doductions		7e(5)	0
	f	(5) Total deductions		7e(5)	0

P	Part	III Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportin employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a unit	. Where con	tracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision	c	Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	v a	Supplemental unemp	ployment h	Prescription drug
	ъĒ	Stop loss (large deductible)	j HMO contract		PPO contract	,	I Indemnity contract
	• L						
	m	X Other (specify) BASIC AD&D					
9	Fyne	erience-rated contracts:					
Ŭ		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	-	9a(2)			
		(3) Increase (decrease) in unearned premium rese	-	9a(3)			
		(4) Earned ((1) + (2) - (3))	L			9a(4)	
	b	Benefit charges (1) Claims paid	F	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		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 a	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)				9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
4.0		Dividends or retroactive rate refunds due. (Do not	t include amount entered	in line 9c(2)	.)	9e	
10		onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca				10a	5282
	b	If the carrier, service, or other organization incurre				10b	

11 Did the insurance company fail to provide any information necessary to complete Schedule A?	1	Yes	X No	

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

Provision of Information

Specify nature of costs.

Part IV

	-						
SCHEDULE		Insurar	nce Information	n		O	//B No. 1210-0110
(Form 5500 Department of the Treas	,	This schedule is require	ed to be filed under section	on 104 of th	e		
Internal Revenue Servi	ice		ncome Security Act of 19				2021
Department of Labor Employee Benefits Security Adr		File as an	attachment to Form 55	500.			
Pension Benefit Guaranty Co	rporation	 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			This Fo	rm is Open to Public Inspection	
				1/2021	·		
A Name of plan ZETA ASSOCIATES INC	ORPORATED	INDIVIDUAL BENEFIT ACCO	JNT		e-digit number (PN	N) 🕨	501
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN)					(EIN)		
ZETA ASSOCIATES INCORPORATED 54-1279046					. ,		
		ning Insurance Contrac					
1 Coverage Information:							
(a) Name of insurance can LIFE INSURANCE COMPA		HAMERICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	contract year
(6) EIN	code	identification number	policy or contrac		(f)	From	(g) To
23-1503749	65498	LK962754			01/01/202	1	12/31/2021
2 Insurance fee and comr descending order of the		tion. Enter the total fees and to	otal commissions paid. L	ist in line 3.	the agents,	brokers, and o	other persons in
(a) Total a	amount of comn	nissions paid		(b) To	otal amount	of fees paid	
		20580					3427
3 Persons receiving com		es. (Complete as many entrie		•			
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
MCGRIFF INSURANCE SE	ERVICES, INC.		BOX 896620 RLOTTE, NC 28289				
(b) Amount of sales an	nd base	Fe	ees and other commissio	ns paid			_
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	20580	3427					
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
							T

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

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Page **2 –** 1

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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

(a) Name and address of the agent, broker, 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

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

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			1

Schedule A (Form 5500) 2021

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F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may b this report.	be treated as a unit for purposes of
4	Curr	rent value of plan's interest under this contract in the general account at year end	4
5		rent value of plan's interest under this contract in separate accounts at year end	5
6		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 connection with the acquisition or retention of the contract or policy, enter amount.	6d
		Specify nature of costs	
	е	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	Con	tracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immediate participation guarantee	
		(3) ☐ guaranteed investment (4) ☐ other ►	
	L		74
	b	Balance at the end of the previous year	7b
	С	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)	
		(6)Total additions	7c(6) 0
	d	Total of balance and additions (add lines 7b and 7c(6)).	7d
	е	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	
		(4) Other (specify below)	
		(5) Total deductions	7e(5)
	f	(5) Total deductions	7f

Specify nature of costs.

Ρ	art	111	Welfare Benefit Contract Information If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of er ing purpos	es if such contr	racts are e	xpe	rience-rated as a unit	t. Where co	ontracts cover indi	
8	Ben	efit ar	nd contract type (check all applicable boxes)								
	а	He	alth (other than dental or vision)	b Der	ntal	C	; []	Vision		d Life insura	nce
	еĪ	Те	mporary disability (accident and sickness)	f 🗙 Lor	ig-term disabilit	ty g	ıП	Supplemental unem	ployment	h Prescriptio	n drug
	iΓ	_	op loss (large deductible)		O contract			PPO contract		I Indemnity of	•
	• L m [J []	e contract		·П				Jonnaor
	m	Ot	her (specify)								
9	Evne	ariono	ce-rated contracts:								
Ŭ			iums: (1) Amount received		[9a(1)				-	
	•••••		ncrease (decrease) in amount due but unpaid			9a(2)					
		• •	ncrease (decrease) in unearned premium res		ľ	9a(3)				-	
		• •	arned ((1) + (2) - (3))		L				9a(4)		
	b	Bene	efit charges (1) Claims paid			9b(1)					
		(2) Ir	ncrease (decrease) in claim reserves			9b(2)					
		(3) Ir	ncurred claims (add (1) and (2))						9b(3)		
		• •	laims charged						9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accru	al basis)						
		((A) Commissions			9c(1)(A	-			_	
		((B) Administrative service or other fees			9c(1)(B				_	
			(C) Other specific acquisition costs		ľ	9c(1)(C				_	
		```	(D) Other expenses		ľ	9c(1)(D				_	
			(E) Taxes		ľ	9c(1)(E)				_	
			(F) Charges for risks or other contingencies.		-	9c(1)(F) 9c(1)(G				_	
			(G) Other retention charges		=				9c(1)/H		
			(H) Total retention		_	-	_		9c(1)(H)	)	
	٦		Dividends or retroactive rate refunds. (These			L.			9c(2)		
	d		us of policyholder reserves at end of year: (1 Claim reserves	,					9d(1)		
		• •							9d(2) 9d(3)		
	۵	• •	Other reserves dends or retroactive rate refunds due. (Do n						90(5) 9e		
10			erience-rated contracts:				(~)	/	36		
	a	•	I premiums or subscription charges paid to c	arrier					10a		205796
	_		e carrier, service, or other organization incuri								
			ation of the contract or policy other than rep						10b		

Part IV	Provision of Information			
11 Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the an	swer to line 11 is "Yes," specify the information not provided.			

SCHEDULE C	Service Provider	0	MB No. 1210-0110	
(Form 5500)	2021			
Department of the Treasury Internal Revenue Service	This schedule is required to be filed und Retirement Income Security A		2021	
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	File as an attachmen	t to Form 5500.	This Fo	orm is Open to Public Inspection.
For calendar plan year 2021 or fiscal pla	n year beginning 01/01/2021	and ending 12/31	1/2021	•
A Name of plan		<b>B</b> Three-digit		
ZETA ASSOCIATES INCORPORATED	DINDIVIDUAL BENEFIT ACCOUNT	plan number (PN)	•	501
<b>C</b> Plan sponsor's name as shown on lin	ne 2a of Form 5500	<b>D</b> Employer Identification	on Number (l	EIN)
ZETA ASSOCIATES INCORPORATED	)	54-1279046		
Part I Service Provider Info	rmation (see instructions)			
Information on Persons Rece Check "Yes" or "No" to indicate whethe	clude that person when completing the rema eiving Only Eligible Indirect Comp r you are excluding a person from the remain in received the required disclosures (see inst	Densation Inder of this Part because they receive		
	e name and EIN or address of each person pation. Complete as many entries as needed		the service	providers who
(b) Enter name	e and EIN or address of person who provided	d you disclosures on eligible indirect	compensatio	n
(b) Enter name	e and EIN or address of person who provided	d you disclosures on eligible indirect	compensatio	n
(b) Enter name	e and EIN or address of person who provided	d you disclosures on eligible indirect	compensatio	n

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

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CIGNA HEALTH & LIFE INSURANCE CO

## 59-1031071

<b>(b)</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?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0					
12 38 50 13 49 56 31 62	PROVIDES CLAIM & SERVICES	0	Yes 🛛 No 🗌	Yes 🕺 No 🗌	0	Yes 🕺 No 🗌				
	(a) Enter name and EIN or address (see instructions)									

<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	<b>(e)</b> 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?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?				
			Yes 🗌 No 🗍	Yes 🗌 No 🗌		Yes 🗌 No 🗍				
	(a) Enter name and EIN or address (see instructions)									

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	
			Yes 🗌 No 🗍	Yes 🗌 No 🗍		Yes No

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0						
			Yes No	Yes 🗌 No 🗌		Yes 🗌 No 🗌					
		(	(a) Enter name and EIN or	address (see instructions)							

<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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?	(g) 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											
	(a) Enter name and EIN or address (see instructions)										

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	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	
			Yes No	Yes No		Yes No

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Part I	Service Provider Information (continued)		
or provid questions provider	ported on line 2 receipt of indirect compensation, other than eligible indirect compe es contract administrator, consulting, custodial, investment advisory, investment m s for (a) each source from whom the service provider received \$1,000 or more in in gave you a formula used to determine the indirect compensation instead of an amo tries as needed to report the required information for each source.	anagement, broker, or recordkeeping direct compensation and (b) each so	services, answer the following urce 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
			compensation
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility ne 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	(e) Describe the indirect of	compensation, including any
		formula used to determine	the service provider's eligibility ne indirect compensation.
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
	<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility ne indirect compensation.

Pa	art II	Service Providers Who Fail or Refuse to	Provide Infori	nation	
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.				
		ter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide	
	<b>(a)</b> En	ter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide	
	<b>(a)</b> En	ter name and EIN or address of service provider (see instructions)	(b) Nature of Service	(C) Describe the information that the service provider failed or refused to provide	
_			Code(s)		
	<b>(a)</b> En	ter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide	
_	<b>(a)</b> En	ter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide	
	<b>(a)</b> En	ter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide	

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Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
а	Name:		b EIN:		
С	Positio	:			
d	Addres	X.	e Telephone:		
EX	planation				
а	Name:		b EIN:		
C	Positio	:			
d	Addres		e Telephone:		
Ex	planation				
а	Name:		b EIN:		
C	Positio	:			
d	Addres		e Telephone:		
Ex	planation				
а	Name:		b EIN:		
<u>а</u> С	Positio				
d	Addres		e Telephone:		
-	,				
Explanation:					
<u>a</u>	Name:		b EIN:		

e Telephone:

d Address:

Explanation: