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 1210 - 0089

2022

This Form is Open to Public Inspection

Pa	rt I Annual Report Identification Info	ormation		·					
	or calendar plan year 2022 or fiscal plan year beginn	ing $01/01/2$	2022 and ending	12/31/2022					
A ·	his return/report is for: a multiemployer pla	n 📙 am	ultiple-employer plan (File	ers checking this box must attac	h a list of				
	_	par	ticipating employer inform	nation in accordance with the for	m instr.)				
	🛚 a single-employer p	lan 📙 a D	FE (specify)						
В -	his return/report is: the first return/repo	rt 📙 the	final return/report						
	an amended return	/report 📗 a sl	nort plan year return/repo	rt (less than 12 month <u>s)</u>					
C	f the plan is a collectively-bargained plan, check here			<u></u> ▶∐					
D (Check box if filing under: Form 5558	☐ aut	omatic extension	the DFVC program					
_	special extension (e			. 🗖					
	f this is a retroactively adopted plan permitted by SEC		, check here	<u>▶ </u>					
_	rt II Basic Plan Information - enter all re	quested information		1					
	Name of plan			1b Three-digit	501				
	TA ASSOCIATES INCORPORATED			plan number (PN)	201				
T1/	INDIVIDUAL BENEFIT ACCOUNT 1c Effective date of plan 06/01/1984								
2a	Plan sponsor's name (employer, if for a single-employer pla			2b Employer Identification Number (EIN)					
	Mailing address (include room, apt., suite no. and street, or	· · · · · · · · · · · · · · · · · · ·		54-1279046					
ZE'	City or town, state or province, country, and ZIP or foreign practice. CALLES INCORPORATED	oostal code (if foreign, se		2c Plan Sponsor's telephone number 703-385-7050					
				2d Business code (see instruction 541700	ctions)				
10	302 EATON PLACE			341700					
_	ITE 500								
		2030							
Cau	tion: A penalty for the late or incomplete filing of th	nis return/report will l	oe assessed unless reas	onable cause is established.					
	penalties of perjury and other penalties set forth in the instructions, I do		, , ,	anying schedules, statements and attachm	ents, as well				
as the	electronic version of this return/report, and to the best of my knowledg	e and belief, it is true, correct,	and complete.						
SIG	N								
HEF	F	04/24/2023		atombo a constant at the					
	Signature of plan administrator	Date	Enter name of individual	signing as plan administrator					
SIG	N	04/24/2023	CIIE CIIV						
HEF	E	04/44/4043	DOE DOV						

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

Date

Date

Signature of employer/plan sponsor

Signature of DFE

Form 5500 (2022) v. 220413

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

Enter name of individual signing as DFE

	Form 5500 (2022)	Page 2											
3a	Plan administrator's name and address 🛮 Same as Plan Sponsor		3b Administra						strator's	ator's EIN			
							3с	Adminis	strator's	telephon	e number		
	If the name and/or EIN of the plan sponsor or the plan name has chang enter the plan sponsor's name, EIN, the plan name and the plan number Sponsor's name Plan Name					•		for this	s plan,	4b EIN			
5	Total number of participants at the beginning of the plan year								5		283		
6 a	Number of participants as of the end of the plan year unless otherwise 6a(1), 6a(2), 6b, 6c, and 6d). (1) Total number of active participants at the beginning of the plan year								6a(1)	1	283		
	(2) Total number of active participants at the end of the plan year									1	481		
	Retired or separated participants receiving benefits								- 				
	Other retired or separated participants entitled to future benefits								•		481		
	Subtotal. Add lines 6a(2), 6b, and 6c Deceased participants whose beneficiaries are receiving or are entitled								•		401		
							•						
g	Number of participants with account balances as of the end of the plan complete this item)	year (or	nly def	ined	cont	tributi	ion pla	ans					
	Number of participants who terminated employment during the plan yea less than 100% vested								6h				
7	Enter the total number of employers obligated to contribute to the plan this item)		-	-	-		-	e 	. 7				
b 4A		e codes	from t	he L	ist of	f Plan	ı Char	acteristi	cs Code	es in the i			
9a	Plan funding arrangement (check all that apply)	1	77	i .			nent (d	check al	ll that ap	ply)			
	(1) Insurance	1	1) 🖺	ı	surar		440	() (0) :					
	(2) Code section 412(e)(3) insurance contracts	1	2)	1		sectio	n 412	(e)(3) ins	surance	contracts	S		
	(3) Trust		3) 4) Y	ı	ust		-46	41					
10	(4) A General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)		t) X ched,					the spo d, enter		ber atta	ched.		
2	Pension Schedules	b c	enera	al S c	hadı	ulae							
a	(1) R (Retirement Plan Information)	_	1)	ار ا	, i c ui	H	(Fin-	ancial In	nformatio	nn)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		2)			п 1	•			on - Smal	l Plan)		
	Purchase Plan Actuarial Information) - signed by the plan actuary	(;	2) 3) X 4) X		6	A C	(Ins	urance I	nformat		,		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		5)			D	•			Plan Infor	•		
	Information) - signed by the plan actuary		6)			G				on Sched			

Page 3

Form 5500 (2022)

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

2022

This Form is Open to Public Inspection

For calendar plan year 20	22 or fiscal plan	year beginning 01/0	1/202	2	and ending	J	12/31/2022	
A Name of plan	3 M M C T 3 T						ree-digit	E 0.1
ZETA ASSOCI	ATES IN	CORPORATED			-	pla	an number (PN)	501
C Plan sponsor's nar ZETA ASSOCIA						D Em	nployer Identification $54-127904$	
		erning Insurance Co Schedule A. Individual con						
1 Coverage Informat	ion:							
(a) Name of insurance	carrier							
CIGNA HEALT	H AND L	IFE INSURANCE	COMPA	NY AND	AFFILIA	TES		
(b) EIN	(c) NAIC	(d) Contract or	(e)	Approximate	number of pers	ons	Policy or co	ntract year
(b) Liiv	code	identification number	cover	ed at end of	policy or contrac	t year	(f) From	(g) To
59-1031071	67369	3334243				718	01/01/2022	12/31/2022
2 Insurance fee and in descending orde		formation. Enter the total fe nt paid.	es and to	tal commissi	ons paid. List in	line 3 th	ne agents, brokers, ar	nd other persons
(a) ⊺	otal amount o	f commissions paid			(b) T	otal am	ount of fees paid	
		205	,048					6,052
3 Persons receiving		and fees. (Complete as man	•					
MCGRIFF INS		nd address of the agent, bro SERVICES . INC •	oker, or ot	her person to	o whom commiss	sions or	fees were paid	
CHARLOTTE	ordinon ,	onivious, inc.						
CHARLOTTE		NC 272	14					
(b) Amount of sale			Fees and other commissions paid					(e) Organization
commissions	s paid	(c) Amount			(d) Purpo	se		code
	205,048	6,052						3
	•	,						
	(a) Name ar	nd address of the agent, bro	ker, or ot	her person to	o whom commiss	sions or	fees were paid	
(b) Amount of sales and base Fees and other commissions paid						(e) Organization		
commissions	s paid	(c) Amount			(d) Purpo	se		code

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

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

P	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of suc purposes of this report.	ch individu	al contracts with each o	carrier m	nay be treated as a unit for
4	Current	value of plan's interest under this contract in the general account a	at year en	b	4	
<u>5</u>	Current	value of plan's interest under this contract in separate accounts at	year end		5	
6	Contract	s With Allocated Funds:				
а	State t	the basis of premium rates				
b	P remiu	ıms paid to carrier			6b	
C	Premiu	ums due but unpaid at the end of the year			6с	
C	If the c	carrier, service, or other organization incurred any specific costs in	connection	n with		
	the ac	quisition or retention of the contract or policy, enter amount			6d	
		y nature of costs				
e	Type c	of contract: (1) 🔲 individual policies (2) 📗 group deferre				
	(3)	other (specify)				
_					Ī	
<u>_f</u>		ract purchased, in whole or in part, to distribute benefits from a te				
7		acts With Unallocated Funds (Do not include portions of these con	7			
а	Type c	of contract: (1) deposit administration (2)	7 .	ate participation guarant	ee	
		(3) guaranteed investment (4)	other	•		
L				ı	7b	
		te at the end of the previous year	7c(1)		70	
·		ons: (1) Contributions deposited during the year				
		vidends and credits	7c(2)			
		erest credited during the year	7c(4)			
		ansferred from separate account	7c(5)			
	(5) Ot	her (specify below)	10(0)			
	(6) To	tal additions			7c(6)	0
c	-	of balance and additions (add lines 7b and 7c(6))			7d	
e			Γ			
-		sbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		Iministration charge made by carrier				
		ansferred to separate account	7e(3)			
		her (specify below)	7e(4)			
	>	· · · · · · · · · · · · · · · · · · ·				
	(5) To	tal deductions			7e(5)	0
f		ce at the end of the current year (subtract line 7e(5) from line 7d) .			7f	

Pa	art III Welfare Benefit Contract Information				
	If more than one contract covers the same group of empl				
	employee organization(s), the information may be combin as a unit. Where contracts cover individual employees, the	•	•		•
	treated as a unit for purposes of this report.	ie entire group	o oi such individual (contracts wit	in each camer may be
8	Benefit and contract type (check all applicable boxes)		- []		₄ □
	a X Health (other than dental or vision) b X Dental		c X Vision		d Life insurance
	Temporary disability (accident and sickness)	-	g Supplementa		
	Stop loss (large deductible)	tract	k PPO contract	ţ	I X Indemnity contract
9	m Other (specify) ▶				
	Experience-rated contracts:	0-(4)	2 0 1	2 001	
а		2 (2)		3,084 8,912	
	(2) Increase (decrease) in amount due but unpaid			0,912	
	(3) Increase (decrease) in unearned premium reserve			0-(4)	3,834,172
	(4) Earned ((1) + (2) - (3))		2 / 0	9a(4) 3,210	3,034,172
D	Benefit charges (1) Claims paid				
	(2) Increase (decrease) in claim reserves			7,437	2 455 772
	(3) Incurred claims (add (1) and (2))			9b(3)	3,455,773 3,455,773
	(4) Claims charged			9b(4)	3,455,773
С	Remainder of premium: (1) Retention charges (on an accrual basis) -				
	(A) Commissions				
	(B) Administrative service or other fees				
	(C) Other specific acquisition costs		20	1 112	
	(D) Other expenses	- (.)(-)		1,113	
	(E) Taxes		8	7,419	
	(F) Charges for risks or other contingencies				
	(G) Other retention charges	9c(1)(G)		0 (4)(1)	270 522
	(H) Total retention			9c(1)(H)	378,532
	(2) Dividends or retroactive rate refunds. (These amounts were	•	_	9c(2)	
a	Status of policyholder reserves at end of year: (1) Amount held to pr			9d(1)	400 201
	(2) Claim reserves			9d(2)	499,381
	(3) Other reserves			9d(3)	
	Dividends or retroactive rate refunds due. (Do not include amount en	ntered in line 9	c(2).)	9e	
10	Nonexperience-rated contracts:		1	10-	1 0/5 7/0
a	Total premiums or subscription charges paid to carrier			10a	1,945,769
a	If the carrier, service, or other organization incurred any specific cos				
	the acquisition or retention of the contract or policy, other than repo	,		40.	
	above, report amount			10b	
S	pecify nature of costs.				

Pa	art IV	Provision of Information			
11	Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
12	If the a	nswer 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2022

This For	m is	Open	to
Public	Insp	ectio	า

For calendar plan year 20	122 or fiscal plan	year beginning 01/0	1/202	22 and endi	ng	12/31/2022		
A Name of plan					B Th	ree-digit		
ZETA ASSOCI	ATES IN	CORPORATED			pla	an number (PN)	501	
C Plan sponsor's na	me as shown	on line 2a of Form 5500			D En	nployer Identification	Number (EIN)	
ZETA ASSOCI	ATES IN	CORPORATED				54-127904		
		cerning Insurance Co e Schedule A. Individual cont		- '				
1 Coverage Informati	tion:							
(a) Name of insurance	e carrier							
LIFE INSURA	NCE COM	PANY OF NORTH	AMERI	CA				
(b) EIN	(c) NAIC	(d) Contract or	(e)	Approximate number of pe	rsons	Policy or co	ntract year	
(6) (11)	code	identification number	identification number covered at en			(f) From	(g) To	
23-1503749	65498	TD1960459				01/01/2022	12/31/2022	
2 Insurance fee and in descending ord		nformation. Enter the total feather that is the second of	es and to	tal commissions paid. List ir	n line 3 th	ne agents, brokers, ar	nd other persons	
(a) 1	Total amount o	of commissions paid		(b)	Total am	ount of fees paid		
			2				4	
3 Persons receiving		and fees. (Complete as many						
MCGRIFF INS		nd address of the agent, bro SERVICES, INC.	ker, or ot	her person to whom commi	ssions or	fees were paid		
P.O. BOX 89		belivious, inc.						
CHARLOTTE		NC 282	89					
(b) Amount of sale			Fees	s and other commissions pa	iid		(e) Organization	
commission	s paid	(c) Amount		(d) Purp	ose	code		
	2	4						
	(a) Name a	nd address of the agent, bro	ker, or ot	her person to whom commi	ssions or	fees were paid		
(b) Amount of sales and base Fees and other commissions paid								
commission	s paid	(c) Amount		<u> </u>		Organization code		
		(C) Amount		(d) Purp	J086			

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Fees and other commissions paid

commissions paid

(c) Amount

(d) Purpose

Organization

Р	Part II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of s purposes of this report.	uch individual contracts with each	carrier m	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general accoun	t at year end	. 4	
5	Current value of plan's interest under this contract in separate accounts	at year end	. 5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6c	
C	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 defe	rred annuity		
	(3) other (specify)			
			г	_
_f	If contract purchased, in whole or in part, to distribute benefits from a	-		
7	Contracts With Unallocated Funds (Do not include portions of these co			
а	Type of contract: (1) deposit administration (2)	immediate participation guarar	ntee	
	(3) guaranteed investment (4)	☐ other ►		
	Balance at the end of the previous year	— <i>f</i> - >	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)	7c(5)		
	•			
			7 (0)	•
	(6) Total additions		7c(6)	0
	Total of balance and additions (add lines 7b and 7c(6))		7d	
е	Deductions:	7 (4)		
	(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)	7e(4)		
	>			
			7 (5)	^
_	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Pá	art III		Welfare Benefit Contract Information					
			If more than one contract covers the same group of employ employee organization(s), the information may be combined					nto d
			as a unit. Where contracts cover individual employees, the	•	•		•	
			treated as a unit for purposes of this report.					,
8	Rene	ofit a	nd contract type (check all applicable boxes)					
	a	7	alth (other than dental or vision) b Dental		c Vision		d∏ı	fe insurance
	e	-	mporary disability (accident and sickness) f Long-term d	lisability	g Supplementa	al unemplovr	. H	rescription drug
	i 🗀	7	pp loss (large deductible) j HMO contra		k PPO contrac		. —	demnity contract
	m		ner (specify) STATUTORY DISABILITY				Ц.,	,
9			ce-rated contracts:					
а	Pren	nium	s: (1) Amount received	9a(1)				
	(2)	Incr	ease (decrease) in amount due but unpaid	9a(2)				
	(3)	Incr	ease (decrease) in unearned premium reserve	9a(3)				
	(4)	Earı	ned ((1) + (2) - (3))			9a(4)		
b	Bene	efit c	harges (1) Claims paid	9b(1)				
	(2)	Incr	ease (decrease) in claim reserves	9b(2)				
	(3)	Incu	ırred claims (add (1) and (2))			9b(3)		
	٠,		ms charged			9b(4)		
С	Rem	aind	er of premium: (1) Retention charges (on an accrual basis)					
				9c(1)(A)				
		(B)		9c(1)(B)				
		(C)		9c(1)(C)				
		(D)		9c(1)(D)				
		(E)		9c(1)(E)				
		(F)		9c(1)(F)				
		(G)	_	9c(1)(G)		0 - (4) (1.1)		
		(H)	Total retention			9c(1)(H)		
			dends or retroactive rate refunds. (These amounts were U pa			9c(2)		
a			policyholder reserves at end of year: (1) Amount held to prov			9d(1)		
			m reserves			9d(2)		
_			er reserves (Danatical Laboratoria de la Companyoria dela Companyoria de la Companyoria de la Companyoria dela Companyoria de la Companyoria dela Companyoria dela Companyoria de la Companyoria			9d(3) 9e		
<u>e</u>			s or retroactive rate refunds due. (Do not include amount ente	erea in line s	IC(2).)) 9e		
а		•	rience-rated contracts: miums or subscription charges paid to carrier			10a		
b			rier, service, or other organization incurred any specific costs			104		
_			isition or retention of the contract or policy, other than reporte					
			eport amount			10b		
S			ure of costs.				I	
_								

Pa	art IV	Provision of Information			
11	Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
		unswer 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

For calendar plan year 20	22 or fiscal plan	year beginning 01/0	1/202	2 an	nd ending		12/31/2022	2	
A Name of plan					В	Thi	ree-digit		
ZETA ASSOCI	ATES INC	CORPORATED				pla	n number (PN)	·	501
		n line 2a of Form 5500			D	Em	ployer Identification		oer (EIN)
ZETA ASSOCI							54-127904		
		erning Insurance Con Schedule A. Individual cont							
1 Coverage Informati	tion:								
(a) Name of insurance	e carrier								
LIFE INSURA	NCE COM	PANY OF NORTH	AMERI	CA					
(b) EIN	(c) NAIC	(d) Contract or	(e)	Approximate number	of person	s	Policy or c	ontrac	t year
code identification number covered at end of policy or contr		contract y	ear	(f) From		(g) To			
23-1503749	 65498 I	LK750914					01/01/2022	 212/	31/2022
2 Insurance fee and	commission in	formation. Enter the total fee	es and to	tal commissions paid.	. List in line				
in descending ord									
(a) ¹	Total amount of	f commissions paid	106		(b) Tota	l amo	ount of fees paid		
0 -			,426						0
3 Persons receiving		and fees. (Complete as many					face was real d		
MCGRIFF INS		nd address of the agent, bro SERVICES, INC.	ker, or ou	ner person to whom c	COMMINISSION	IS OF	rees were paid		
P.O. BOX 89		,,							
CHARLOTTE		NC 282	89						
(b) Amount of sale	es and base		Faas	and other commission	nns naid				(e)
commission			1 000		•	Organization			
		(c) Amount		(0	d) Purpose	!		-+	code
	11,426	0							3
	(a) Name ar	nd address of the agent, bro	ker, or ot	her person to whom o	commissio	ns or	fees were paid		
(b) Amount of sales and base Fees and other commissions paid (e)									(e)
(b) Amount of sales and base Fees and other commissions paid commissions paid Org						Organization			
	•	(c) Amount		(0	d) Purpose	!		\perp	code

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

commissions paid

(c) Amount

(d) Purpose

Organization

P	Part II	Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of su purposes of this report.	ch individual contracts with eac	h carrier m	ay be treated as a unit for
<u>4</u>	Current	value of plan's interest under this contract in the general account	at year end		
		value of plan's interest under this contract in separate accounts a	t year end	5	
6	Contrac	cts With Allocated Funds:			
ŧ	3 State	the basis of premium rates			
k	P rem	iums paid to carrier		6b	
C	Prem	iums due but unpaid at the end of the year		6c	
_		carrier, service, or other organization incurred any specific costs in			
	the a	equisition or retention of the contract or policy, enter amount		6d	
		ify nature of costs			
e	T ype	of contract: (1) individual policies (2) group deferr	ed annuity		
	(3)	other (specify)			
	-			г	¬
<u>_f</u>		stract purchased, in whole or in part, to distribute benefits from a te			
7		racts With Unallocated Funds (Do not include portions of these cor		•	
ä	Type	of contract: (1) deposit administration (2)	immediate participation guara	antee	
		(3) guaranteed investment (4)	_ other ▶		
L				76	
		nce at the end of the previous year	l — () l	. 7b	
•		ions: (1) Contributions deposited during the year			
		lividends and credits	= (0)		
		nterest credited during the year	 		
		ransferred from separate account			
	(5)	Other (specify below)	70(3)		
	(6) T	otal additions		7c(6)	0
c	_	of balance and additions (add lines 7b and 7c(6))			-
E		ctions:			
		isbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		dministration charge made by carrier	-		
		ransferred to separate account	7e(3)		
		Other (specify below)			
	>	· · · · · · · · · · · · · · · · · · ·	` ' '		
	(5) T	otal deductions		7e(5)	0
f		nce at the end of the current year (subtract line 7e(5) from line 7d)		. 7f	

P	art II	Welfare Benefit Contract Information				
		If more than one contract covers the same group of empl	oyees of the	same emplover(s) o	r members of	f the same
		employee organization(s), the information may be combin	•			
		as a unit. Where contracts cover individual employees, th	e entire group	o of such individual	contracts wi	th each carrier may be
		treated as a unit for purposes of this report.				
8	Ben	efit and contract type (check all applicable boxes)		_		
	a 2	Health (other than dental or vision) b Dental		C Vision		d ∐ Life insurance
	e	Temporary disability (accident and sickness) f Long-term	disability	g Supplement	al unemployr	ment h Prescription drug
	i	Stop loss (large deductible) j HMO con	tract	k PPO contrac	ct	I Indemnity contract
	m	Other (specify) ► SHORT-TERM DISABILITY				
9	Exp	erience-rated contracts:				
а		miums: (1) Amount received	9a(1)			
	(2)	Increase (decrease) in amount due but unpaid				
		Increase (decrease) in unearned premium reserve				
		Earned ((1) + (2) - (3))			9a(4)	
b		efit charges (1) Claims paid				
		Increase (decrease) in claim reserves				
	(3)	Incurred claims (add (1) and (2))			9b(3)	
	(4)	Claims charged			9b(4)	
С	Ren	nainder 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			1	
		(H) Total retention			9c(1)(H)	
_		Dividends or retroactive rate refunds. (These amounts were			9c(2)	
d		rus of policyholder reserves at end of year: (1) Amount held to pr			9d(1)	
		Claim reserves			9d(2)	
		Other reserves			9d(3)	
<u>e</u>		dends or retroactive rate refunds due. (Do not include amount er	ntered in line 9	9c(2).)	9e	
10		experience-rated contracts:			40-	
a		al premiums or subscription charges paid to carrier			10a	
b		e carrier, service, or other organization incurred any specific cos				
		acquisition or retention of the contract or policy, other than repo	rted in Part I,	line 2	106	
_		ve, report amount			10b	
S	pecify	nature of costs.				

Pa	art 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. ▶			

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

2022

This For	m is	Open	to
Public	Insp	ection	1

For calendar plan year 20	22 or fiscal plan	year beginning 01/0	1/202	22 and	ending	12/31/2022			
A Name of plan ZETA ASSOCI	ATES IN	CORPORATED				nree-digit an number (PN)	501		
C Plan sponsor's nai ZETA ASSOCI		on line 2a of Form 5500			D Er	nployer Identification 54-127904			
		cerning Insurance Co Schedule A. Individual cont							
1 Coverage Informat	tion:								
(a) Name of insurance	e carrier								
		PANY OF NORTH	AMERI	CA					
(b) EIN	(c) NAIC	(d) Contract or	(e)	Approximate number of	f persons	Policy or co	ntract year		
(b) EIN	code	identification number	cover	ed at end of policy or co	ontract year	(f) From	(g) To		
23-1503749	65498	FLX963886 01/01/202212							
2 Insurance fee and in descending order		formation. Enter the total fe nt paid.	es and to	tal commissions paid. L	ist in line 3 tl	ne agents, brokers, ar	nd other persons		
(a) 1	Total amount o	f commissions paid	100		(b) Total am	ount of fees paid			
			,139				0		
3 Persons receiving		and fees. (Complete as man							
MCGRIFF INS		nd address of the agent, bro SERVICES, INC.	oker, or or	rier person to whom con	mmissions o	r lees were pald			
P.O. BOX 89		,							
CHARLOTTE		NC 282	89						
(b) Amount of sale			Fees and other commissions paid				(e) Organization		
commissions	s paiu	(c) Amount		(d)	Purpose		code		
	16,139								
	(a) Name a	nd address of the agent, bro	ker, or ot	her person to whom co	mmissions o	r fees were paid			
(b) Amount of sales and base Fees and other commissions paid commissions paid					(e) Organization code				
	- Paid	(c) Amount		(d)	Purpose	Purpose			

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

Fees and other commissions paid

(b) Amount of sales and base

commissions paid

(c) Amount

(d) Purpose

(e)

Organization

Р	Part II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of s purposes of this report.	uch individual contracts with each	carrier m	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general accoun	t at year end	. 4	
5	Current value of plan's interest under this contract in separate accounts	at year end	. 5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6c	
C	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			
e	Type of contract: (1) 🔲 individual policies (2) 📙 group defe	rred annuity		
	(3) other (specify)			
			г	_
_f	If contract purchased, in whole or in part, to distribute benefits from a	-		
7	Contracts With Unallocated Funds (Do not include portions of these co			
а	Type of contract: (1) deposit administration (2)	immediate participation guarar	ntee	
	(3) guaranteed investment (4)	☐ other ►		
	Balance at the end of the previous year	— <i>f</i> - >	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)	7c(5)		
	•			
			7 (0)	•
	(6) Total additions		7c(6)	0
	Total of balance and additions (add lines 7b and 7c(6))		7d	
е	Deductions:	7 (4)		
	(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)	7e(4)		
	>			
			7 (5)	^
_	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Pa	art III	Welfare Benefit Contract Information If more than one contract covers the same group of ememployee organization(s), the information may be comb as a unit. Where contracts cover individual employees, treated as a unit for purposes of this report.	ined for reportin	ng pi	urposes if such	n contracts ar	e experience-rated
8	a He Te	and contract type (check all applicable boxes) ealth (other than dental or vision) mporary disability (accident and sickness) op loss (large deductible) her (specify)		c g k	Vision Supplement PPO contract	al unemployn	nent d X Life insurance Prescription drug Indemnity contract
9	Experien	ce-rated contracts:					
а	Premium	ns: (1) Amount received	. 9a(1)				
	(2) Inci	rease (decrease) in amount due but unpaid	9a(2)				
		rease (decrease) in unearned premium reserve	2 (2)				
		ned ((1) + (2) - (3))				9a(4)	
b		charges (1) Claims paid				. ,	
		rease (decrease) in claim reserves					
		urred claims (add (1) and (2))				9b(3)	
		ims charged				9b(4)	
С		der of premium: (1) Retention charges (on an accrual basis					
		Commissions					
		Administrative service or other fees					
	(C)						
	(D)	Other expenses	0 (4)(5)				
	(E)	Taxes	2 (4)(=)				
	(-)	Charges for risks or other contingencies					
	(G)	Other retention charges	··				
	(H)	Total retention				9c(1)(H)	
	. ,	idends or retroactive rate refunds. (These amounts were	7		_	9c(2)	
d		f policyholder reserves at end of year: (1) Amount held to p		_	_	9d(1)	
_		im reserves				9d(2)	
		er reserves				9d(3)	
е		ls or retroactive rate refunds due. (Do not include amount				9e	
		erience-rated contracts:	Critered in inte	<u> </u>	.,	1 33	
a		emiums or subscription charges paid to carrier				10a	
b		rrier, service, or other organization incurred any specific co				130	
_		isition or retention of the contract or policy, other than rep					
	•		,		-	10b	
S		eport amounture of costs.				100	
3	poony nat	a. 5 5. 555ta.					

Pa	art IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
	If 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

			-		ERISA Section	103(a)(2).			blic inspection
For calendar plan year 2022 o	or fiscal plan y	ear beginning	01/01	L/202	2	and endin	g	12/31/2022	2
A Name of plan							B Th	ree-digit	
ZETA ASSOCIAT	ES INC	CORPORATE	D				pla	n number (PN)	501
								·	
C Plan sponsor's name	as shown o	n line 2a of Form	5500				D En	nployer Identification	n Number (EIN)
ZETA ASSOCIAT								54-127904	
Part I Informati	ion Conc	erning Insura	nce Cor	ntract (Coverage, F	ees, and (Comm	issions Provide ir	formation for each
contract on	a separate	Schedule A. Indiv	idual conti	racts gro	uped as a unit i	in Parts II and	III can I	be reported on a sir	ngle Schedule A.
1 Coverage Information:	:								
() N ()									
(a) Name of insurance ca	ırrıer								
LIFE INSURANC	E COME	ANY OF N	ORTH A	AMERI	CA				
(b) EIN (d	c) NAIC	(d) Contrac	ct or		Approximate n			Policy or o	contract year
(b) Env	code	identification r	number	covere	ed at end of po	licy or contra	ct year	(f) From	(g) To
23-1503749 6	5 4 98 (K965514						01/01/2022	2 1 2 / 3 1 / 2 0 2 2
2 Insurance fee and cor	mmission int	ormation. Enter t	he total fee	s and to	al commission	s paid. List in	line 3 th	ne agents, brokers,	and other persons
in descending order o	f the amour	t paid.							
(a) Tota	al amount of	commissions pai	d			(b) T	otal am	ount of fees paid	
				483					48
3 Persons receiving con	nmissions a	nd fees. (Comple	te as many	entries a	s needed to re	port all perso	ns).		
		d address of the		ker, or otl	ner person to w	hom commis	sions or	fees were paid	
MCGRIFF INSUR		SERVICES,	INC.						
P.O. BOX 8966	20								
CHARLOTTE		NC	2828	39					
(b) Amount of sales a	nd base			Fees	and other con	nmieeinne nai	d		(e)
commissions pa				1 000	and other con	•			Organization
		(c) Amou	nt			(d) Purp	ose		code
	400		4.0						
	483		48						
	(a) Name an	d address of the	agent, brol	ker, or otl	ner person to w	hom commis	sions or	fees were paid	
		1							1
(b) Amount of sales a	nd base			Fees	and other con	nmissions pai	d		(e)
commissions paid Org					Organization				
		(c) Amou	nt			(d) Purp	ose		code

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

Fees and other commissions paid

(b) Amount of sales and base

commissions paid

(c) Amount

(d) Purpose

Organization

P	Part II	Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of su purposes of this report.	ch individual contracts with eac	h carrier m	ay be treated as a unit for
<u>4</u>	Current	value of plan's interest under this contract in the general account	at year end		
		value of plan's interest under this contract in separate accounts a	t year end	5	
6	Contrac	cts With Allocated Funds:			
ŧ	3 State	the basis of premium rates			
k	P rem	iums paid to carrier		6b	
C	Prem	iums due but unpaid at the end of the year		6c	
_		carrier, service, or other organization incurred any specific costs in			
	the a	equisition or retention of the contract or policy, enter amount		6d	
		ify nature of costs			
e	T ype	of contract: (1) individual policies (2) group deferr	ed annuity		
	(3)	other (specify)			
	-			г	¬
<u>_f</u>		stract purchased, in whole or in part, to distribute benefits from a te			
7		racts With Unallocated Funds (Do not include portions of these cor		•	
ä	Type	of contract: (1) deposit administration (2)	immediate participation guara	antee	
		(3) guaranteed investment (4)	_ other ▶		
L				76	
		nce at the end of the previous year	l — () l	. 7b	
•		ions: (1) Contributions deposited during the year			
		lividends and credits	= (0)		
		nterest credited during the year	 		
		ransferred from separate account			
	(5)	Other (specify below)	70(3)		
	(6) T	otal additions		7c(6)	0
c	_	of balance and additions (add lines 7b and 7c(6))			-
E		ctions:			
		isbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		dministration charge made by carrier	-		
		ransferred to separate account	7e(3)		
		Other (specify below)			
	>	· · · · · · · · · · · · · · · · · · ·	` ' '		
	(5) T	otal deductions		7e(5)	0
f		nce at the end of the current year (subtract line 7e(5) from line 7d)		. 7f	

Pá	art 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 c		•					
	as a unit. Where contracts cover individual employed treated as a unit for purposes of this report.	ees, the entire group of	such individual co	ntracts wit	th each carrier may be			
	treated as a unit for purposes of this report.							
8	Benefit and contract type (check all applicable boxes)	•	_					
	a Health (other than dental or vision)	tal C	Vision		d Life insurance			
	. H	g-term disability g	Supplemental u	ınemployn	nent h Prescription drug			
		O contract K [PPO contract		Indemnity contract			
_	m X Other (specify) ► BASIC AD&D							
9	Experience-rated contracts:	0-(4)						
а	Premiums: (1) Amount received							
	(2) Increase (decrease) in amount due but unpaid							
	(3) Increase (decrease) in unearned premium reserve			0-(4)				
h	(4) Earned ((1) + (2) - (3))			9a(4)				
D	Benefit charges (1) Claims paid							
	(2) Increase (decrease) in claim reserves			9b(3)				
	(3) Incurred claims (add (1) and (2))		·····	9b(4)				
C	(4) Claims charged		·····	3D(1)				
Ū	(A) Commissions							
	(B) Administrative service or other fees							
	(C) Other specific acquisition costs							
	(D) Other expenses	0 (4)(5)						
	(E) Taxes	2 (4)(-)						
	(F) Charges for risks or other contingencies							
	(G) Other retention charges							
	(H) Total retention	<u></u>	g	c(1)(H)				
	(2) Dividends or retroactive rate refunds. (These amounts we	re 🔲 paid in cash, or 📗	credited.)	9c(2)				
d	Status of policyholder reserves at end of year: (1) Amount held	I to provide benefits after	er retirement	9d(1)				
	(2) Claim reserves			9d(2)				
	(3) Other reserves			9d(3)				
<u>e</u>		unt entered in line 9c(2)	.)	9e				
10	•		_	40-				
a	1 3 1			10a				
b	,,g		1					
	the acquisition or retention of the contract or policy, other than	•	-	10b				
0	above, report amount		L	100				
3	Specify nature of costs.							

Provision of Information

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

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

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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

		<u>:</u>		LI IIOA SECTION	100(a)(2).			e intepeetieri
For calendar plan year 202	22 or fiscal plan	year beginning 01/0	1/202	2	and ending		12/31/2022	
A Name of plan						B Th	ree-digit	
ZETA ASSOCIA	ATES IN	CORPORATED				pla	n number (PN)	501
C Plan sponsor's nar	ne as shown o	on line 2a of Form 5500				D Em	ployer Identification	Number (EIN)
ZETA ASSOCIA							[.] 54-127904	
Part I Inform	ation Cond	cerning Insurance Co	ntract (Coverage, F	ees, and C	omm	issions Provide in	formation for each
contract	on a separate	Schedule A. Individual con	tracts gro	uped as a unit i	n Parts II and I	III can l	oe reported on a sin	gle Schedule A.
1 Coverage Informat	ion:							-
(a) Name of insurance	carrier							
LIFE INSURA	NCE COM	PANY OF NORTH	AMERI	CA				
	(c) NAIC	(d) Contract or	(e)	Approximate nu	ımher of perso	nns	Policy or co	ontract year
(b) EIN (c) NAIO code		identification number		ed at end of pol			(f) From	(g) To
							(1) 110111	(9) 10
23-1503749	65498	LK962754					01/01/2022	12/31/2022
		nformation. Enter the total fe	es and to	al commissions	s naid List in li			•
in descending orde			00 4114 10		paid. List iii ii		io agonto, pronoro, a	and outlot porconic
		f commissions paid			(b) To	otal am	ount of fees paid	
(, -		•	,041		(-, -			0
Persons receiving	commissions :	and fees. (Complete as man	•	I as needed to re	nort all nerson	s)		
T Clauria receiving		nd address of the agent, bro					fees were naid	
MCGRIFF INST	URANCE :	SERVICES, INC.	JKO1, 01 01	ici persori to w	110111 00111111100	10110 01	1000 Word paid	
P.O. BOX 89								
CHARLOTTE		NC 282	89					
		1						(e)
(b) Amount of sale	s and base		Fees and other commissions paid					Organization
commissions	s paid	(c) Amount	(d) Purp			se		code
		(o) / unounc			(a) i ai po			
	19,041							
	(a) Namo a	nd address of the agent, bro	kor or ot	hor porson to w	hom commiss	ione or	foos woro paid	
	(a) Name a	nd address of the agent, bit	oker, or or	nei person to w	TIOTTI COTTITTISS	10113 01	iees were paid	
								(e)
(b) Amount of sale	s and base		Fees	and other com	missions paid	s paid		Organization
commissions	s paid	(c) Amount			(d) Purpo	٠		code
		(o) Amount			(a) r dipo			

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

Schedule A (Form 5500) 2022

v. 220413

commissions paid

(c) Amount

(d) Purpose

Р	Part II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of suc purposes of this report.	ch individual contracts with each o	carrier m	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general account a	at year end	4	
5	Current value of plan's interest under this contract in separate accounts at	year end	5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
C	Premiums due but unpaid at the end of the year		6с	
	d If the carrier, service, or other organization incurred any specific costs in			
	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 deferre	ed annuity		
	(3) other (specify)			
				_
f	If contract purchased, in whole or in part, to distribute benefits from a te			
7	Contracts With Unallocated Funds (Do not include portions of these con	tracts maintained in separate acc	ounts)	
а	Type of contract: (1) deposit administration (2)	immediate participation guarant	tee	
	(3) guaranteed investment (4)	other >		
		ı		
	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)		
	•			
	(O) T. I. I. I.I.		70(6)	0
4	(6) Total additions		7c(6) 7d	<u> </u>
	Total of balance and additions (add lines 7b and 7c(6))		74	
-	 Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year 	7e(1)		
	(2) Administration charge made by carrier	7e(3)		
	(3) Transferred to separate account	7e(4)		
	(4) Other (specify below)	75(7)		
	(5) Total deductions		7e(5)	0
f			7f	-

P	art I	I	Welfare Benefit Contract Information					
`			If more than one contract covers the same group of em	olovees of the	sam	e emplover(s) o	r members o	f the same
			employee organization(s), the information may be comb	•				
			as a unit. Where contracts cover individual employees,					
			treated as a unit for purposes of this report.					
8	Day		and no mitter of the color of t					
0	г	_	nd contract type (check all applicable boxes)		ا ـ	٦,,,,		ن بنا الم
	a		alth (other than dental or vision) b Dental		C	Vision		d Life insurance
	e	_	mporary disability (accident and sickness) f X Long-ter		g	Supplement		. 🖯
	<u>'</u>	_	op loss (large deductible)	ntract	K	PPO contrac	t	Indemnity contract
_	m	•	ner (specify)					
9			ce-rated contracts:	- (1)				
а			s: (1) Amount received					
	(2)	Incr	ease (decrease) in amount due but unpaid					
	(3)	Incr	ease (decrease) in unearned premium reserve	9a(3)				
	(4)	Earr	ned ((1) + (2) - (3))	<u></u>			9a(4)	
b	Ber	nefit c	harges (1) Claims paid	9b(1)				
			ease (decrease) in claim reserves					
			urred claims (add (1) and (2))				9b(3)	
	(4)		ms charged				9b(4)	
С	Rer		er of premium: (1) Retention charges (on an accrual basis)				. ,	
			Commissions					
			Administrative service or other fees					
		(C)	Other specific acquisition costs					
		(D)	Other expenses	2 2 2 2 2 2				
		(E)	Taxes	2 (1)(=)				
		(E) (F)	Charges for risks or other contingencies					
		(i) (G)	Other retention charges	2 (1) (2)				
		٠,	Total retention				9c(1)(H)	
	(2)		dends or retroactive rate refunds. (These amounts were				9c(2)	
٨			-				9d(1)	
u			f policyholder reserves at end of year: (1) Amount held to p				9d(1)	
			m reserves					
_			er reserves				9d(3) 9e	
<u>e</u>			s or retroactive rate refunds due. (Do not include amount e	entered in line s)C(2)	1.)	<u> 9e</u>	
10		•	rience-rated contracts:				40-	
a			miums or subscription charges paid to carrier				10a	
b			rier, service, or other organization incurred any specific co					
		-	isition or retention of the contract or policy, other than rep	orted in Part I,	line	2		
	above, report amount						10b	
S	pecif	y natu	ure of costs.					

Pa	art IV Provision of Information				
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	\coprod	Yes	X	No
	If 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 **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

2022

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation	Form 5500.	Public Inspection.	
For calendar plan year 2022 or fiscal p	lan year beginning 01/01/2022	and ending 12	2/31/2022
A Name of plan ZETA ASSOCIATES INC	ORPORATED	B Thre	e-digit number (PN) ▶ 501
C Plan sponsor's name as shown on ZETA ASSOCIATES INC			oloyer Identification Number (EIN) 1–1279046
Part I Service Provider Info	ormation (see instructions)		
You must complete this Part, in accomplete this Part, in accomplete this Part, in accomplete the person's position with the plant	cordance with the instructions, to report the inform ompensation (i.e., money or anything else of mone during the plan year. If a person received only eligited to answer line 1 but are not required to include	tary value) in connection with ible indirect compensation for	services rendered to the plan or which the plan received the
1 Information on Persons Re	ceiving Only Eligible Indirect Compen	 sation	
a Check "Yes" or "No" to indicate wh	ether you are excluding a person from the remaind thich the plan received the required disclosures (see	der of this Part because they r	
•	r the name and EIN or address of each person pro compensation. Complete as many entries as neede	•	s for the service providers
(b) Enter name ar	nd EIN or address of person who provided you dis	closures on eligible indirect co	mpensation
(b) Enter name ar	nd EIN or address of person who provided you dis	closures on eligible indirect co	mpensation
(b) Enter name or	ad EIN or address of parson who provided you dis	alaguras on aligible indirect os	amponentian .
(b) Enter name ar	nd EIN or address of person who provided you dis	biosures on eligible indirect co	mpensation
(b) Enter name ar	nd EIN or address of person who provided you disc	closures on eligible indirect co	mpensation
For Paperwork Reduction Act Notice	e, see the Instructions for Form 5500.		Schedule C (Form 5500) 2022

Schedule C (Form 5500) 2022

v. 220413

Schedule C (Form 5500) 2022	Page 2 -
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation
(1) 5 to 1 and 5 (1) and 1 and	
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	you disclosures on eligible indirect compensation
(a) Enter name and Enter address of person who provided y	ad alsolocal co on oligibio indirect componedition
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation

you ar in tota	nswered "Yes" to line	1a on page 1, co noney or anythin	mplete as many entries	as needed to list each p	ompensation. Except for t erson receiving, directly or indi ered to the plan or their position	rectly, \$5,000 or more
			(a) Enter name and EIN	l or address (see instruc	tions) SEE STAT	EMENT 1
CIGNA	HEALTH & L	IFE INSU	RANCE CO	59-1031071		
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect	Enter total indirect	Did the service
Code(s)	employer, employee	compensation	receive indirect	compensation include	compensation received by	provider give you
	organization, or	paid by the	compensation?	eligible indirect	service provider excluding	a formula instead
	person known to be	plan. If none,	(sources other	compensation, for which the plan	eligible indirect compensation for which you	of an amount or
	a party-in-interest	enter -0	than plan or	received the	answered "Yes" to element	estimated amount?
			plan sponsor)	required disclosures?	(f). If none, enter -0	
12	PROVIDES CL	AIM & SE	RVICES			
38		0.	Yes X No	Yes X No	0.	Yes 🛛 No 🗍
50					_	198 🖺 118 🖺
			(a) Enter name and EIN	l or address (see instruc	tions)	
			. ,	(,	
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect	Enter total indirect	Did the service
Code(s)	employer, employee	compensation	receive indirect	compensation include	compensation received by	provider give you
	organization, or	paid by the	compensation?	eligible indirect compensation, for	service provider excluding eligible indirect	a formula instead
	person known to be	plan. If none,	(sources other	which the plan	compensation for which you	of an amount or
	a party-in-interest	enter -0	than plan or plan sponsor)	received the	answered "Yes" to element	estimated amount?
			piari sporisor)	required disclosures?	(f). If none, enter -0	
			Yes No	Yes No		Yes No
			(a) Enter name and EIN	l or address (see instruc	tions)	
/I= \	(6)	/sn	(5)	10	(-1	/L- \
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employee	Enter direct compensation	Did service provider receive indirect	Did indirect compensation include	Enter total indirect compensation received by	Did the service provider give you
Ooue(s)	organization, or	paid by the	compensation?	eligible indirect	service provider excluding	a formula instead
	person known to be	plan. If none,	(sources other	compensation, for	eligible indirect	of an amount or
	a party-in-interest	enter -0	than plan or	which the plan	compensation for which you	estimated amount?
			plan sponsor)	received the required disclosures?	answered "Yes" to element (f). If none, enter -0	
					(.), onto	
			Yes No	Yes No		Yes No

Part I	Service	Provider	Information	(continued)

i: : (if you reported on line 2 receipt of indirect compensation, other than eligible indirect consists a fiduciary or provides contract administrator, consulting, custodial, investment advising services, answer the following questions for (a) each source from whom the service provider gave you a formula used to determine the amount of the indirect compensation. Complete as many entries as needed to report the	ory, investment management, vider received \$1,000 or more e indirect compensation instea	broker, or recordkeeping in indirect compensation and d of an amount or estimated
	(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	any formula used to deter	t compensation, including mine the service provider's the amount of the mpensation.
	(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	any formula used to deter eligibility for or t	I t compensation, including mine the service provider's the amount of the mpensation.
	(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	any formula used to deter	t compensation, including rmine the service provider's the amount of the mpensation.

SCHEDULE C	OTHER SERVICE	PROVIDER	SERVICE	CODES	STATEMENT	1
NAME		SERVICE	CODES			
CIGNA HEALTH & LIFE	INSURANCE CO	12				
CIGNA HEALTH & LIFE	INSURANCE CO	38				
CIGNA HEALTH & LIFE	INSURANCE CO	50				
CIGNA HEALTH & LIFE	INSURANCE CO	13				
CIGNA HEALTH & LIFE	INSURANCE CO	49				
CIGNA HEALTH & LIFE	INSURANCE CO	56				
CIGNA HEALTH & LIFE	INSURANCE CO	31				
CIGNA HEALTH & LIFE	INSURANCE CO	62				
CODES TO SCHEDULE C	, LINE 2(B)					