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

2018

This Form is Open to Public Inspection

					Inspection			
Part I Ann	ual Report Idei	ntification Information						
For calendar plan	year 2018 or fiscal	plan year beginning 01/01/2018	and ending 12/31/20	18				
A This return/rep	ort is for	a multiemployer plan	a multiple-employer plan (Filers checking the	nis box m	ust attach a list of			
A This returning	5011 13 101.	_	participating employer information in accord	dance wit	th the form instruction	าร.)		
		x a single-employer plan	a DFE (specify)					
B This return/rep	oort 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-bargain	ed plan, check here			•			
D Check box if fi	ling under:	Form 5558	automatic extension	the	e DFVC program			
		special extension (enter description)						
Part II Bas	Part II Basic Plan Information—enter all requested information							
1a Name of plan	1			1b	Three-digit plan	504		
ZETA ASSOCIA	TES INCORPORAT	ED INDIVIDUAL BENEFIT ACCOUN	Т		number (PN) ▶	501		
				1c	Effective date of pla 06/01/1984	an		
	, , ,	if for a single-employer plan) pt., suite no. and street, or P.O. Box)		2b Employer Identification Number (EIN)				
•	•	ountry, and ZIP or foreign postal code	(if foreign, see instructions)		54-1279046			
ZETA ASSOCIATI	ZETA ASSOCIATES INCORPORATED 2c Plan Sponsor's telephone number 703-385-7050							
10302 EATON PLACE SUITE 500 FAIRFAX, VA 22030 2d Business code instructions) 541700					,	;		
Caution: A penal	Ity for the late or in	complete filing of this return/report	t will be assessed unless reasonable cause is	establis	shed.			

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

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	07/12/2019 Date	SUE SUK Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/12/2019	SUE SUK
SIGN	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2018) v. 171027

Form 5500 (2018) Page 2 3a Plan administrator's name and address X Same as Plan Sponsor **3b** Administrator's EIN

		3c Admin	istrator's telephone er
4 a c	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: Sponsor's name Plan Name	4b EIN 4d PN	
5	Total number of participants at the beginning of the plan year	5	231
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a((1) Total number of active participants at the beginning of the plan year	6a(1)	231
a((2) Total number of active participants at the end of the plan year	6a(2)	241
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	241
е	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	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Code. If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Code. 4A 4B 4D 4E 4F 4H 4I 4L		
9a	Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor 9b Plan benefit arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) (3) Trust (4) X General assets of the sponsor (4) X General assets of the sponsor	insurance c	ontracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the numl	oer attached	. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) X C (Service Provided Service) - D (DFE/Participation) - Signed by the plan actuary (5) D (DFE/Participation) - G (Financial Transport of the plan actuary)	nation – Smarmation) er Information	on) ormation)

Page 3

Form 5500 (2018)

Receipt Confirmation Code_

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

		pursuant to EF	RISA section 103(a)(2).			111101011	Inspection	
For calendar plan year 20	18 or fiscal plar	year beginning 01/01/2018		and en	ding 12/3	1/2018		
A Name of plan ZETA ASSOCIATES INC	ORPORATED I	NDIVIDUAL BENEFIT ACCOUNT	г	B Three	e-digit number (PN	N) •	501	
C Plan sponsor's name a ZETA ASSOCIATES INCO		e 2a of Form 5500			yer Identific 1279046	ation Number (EIN)	
		ning Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca CIGNA HEALTH AND LIFE		COMPANY AND AFFILIATES						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			Policy or co	ontract year	
(b) LIN	code	identification number	policy or contract		(f)	From	(g) To	
59-1031071	67369	3334243	695		01/01/2018	8	12/31/2018	
2 Insurance fee and come descending order of the		ntion. Enter the total fees and total	commissions paid. Lis	st in line 3	the agents,	brokers, and of	her persons in	
(a) Total a	amount of comr			(b) To	otal amount	of fees paid	0400	
		176793					2190	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	persons).				
		nd address of the agent, broker, o		n commiss	ions or fees	were paid		
MCGRIFF INSURANCE SI	ERVICES, INC.	GREENS GREENS	SBORO SBORO, NC 27214					
(b) Amount of sales ar	nd base	Fees	and other commission	s paid				
commissions pai		(c) Amount	(d) Purpose	Э		(e) Organization code	
	173543	2190					3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or fees	were paid		
FBP INSURANCE SERVICE	CES	IRVINE,	CA 92602					
(b) Amount of sales ar	nd base	Fees	and other commission	s paid				
commissions pai		(c) Amount	(d) Purpose	Э		(e) Organization code	
	3250							

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		For any distribution and section and the section of	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
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 corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(*) 🗀 🖫			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year			
	-	(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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines 7b and 7c(6))			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(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 I						
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individual.	ing purposes if such conti	racts are expe	erience-rated as a unit. Wh	nere contrac	cts cover individual
8	Bene	efit and contract type (check all applicable boxes)					
	a 🔀	Health (other than dental or vision)	b X Dental	cX	Vision	d□	Life insurance
	e [Temporary disability (accident and sickness)	f Long-term disabilit	<u></u>	Supplemental unemploym		Prescription drug
	. [<u> </u>			I I	<u>u</u> -
	' <u> </u>	Stop loss (large deductible)	j HMO contract	k ∐	PPO contract	IX	Indemnity contract
	m	Other (specify)					
_							
		erience-rated contracts:		2 (1)			
		Premiums: (1) Amount received		9a(1)		205478	
		(2) Increase (decrease) in amount due but unpaid		9a(2)	-	39423	
		(3) Increase (decrease) in unearned premium res				-(4)	2400055
		(4) Earned ((1) + (2) - (3))	i			a(4)	3166055
		Benefit charges (1) Claims paid		· · · ·		84192	
		(2) Increase (decrease) in claim reserves				48154	2632346
		(3) Incurred claims (add (1) and (2))				b(3) b(4)	2632346
		(4) Claims charged				D(4)	2032340
	C	, , , , , , , , , , , , , , , , , , , ,	,	9c(1)(A)		26846	
		(A) Commissions(B) Administrative service or other fees				20040	
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		0 (4)(D)		75077	
		(E) Taxes				72186	
		(F) Charges for risks or other contingencies		9c(1)(F)		72100	
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention			9c	(1)(H)	674109
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)g	c(2)	140400
	d	Status of policyholder reserves at end of year: (1	—	_		d(1)	-
		(2) Claim reserves				d(2)	423116
		(3) Other reserves				d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	1239793
	b	If the carrier, service, or other organization incurr	ed any specific costs in c	onnection with	n the acquisition or		
	_	retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	unt	10b	
	Spe	cify nature of costs.					
	, n4 1	W Provision of Information					
	art I						
		the insurance company fail to provide any inform		ete Schedule	A? Yes	× N	No
12	If th	he answer to line 11 is "Yes," specify the informati	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

		pursuant to E	RISA section 103(a)(2).				Inspection	
For calendar plan year 20°	18 or fiscal plar	year beginning 01/01/2018		and en	ding 12/3	1/2018		
A Name of plan ZETA ASSOCIATES INCO	ORPORATED	INDIVIDUAL BENEFIT ACCOUN	т		e-digit number (PN	N) •	501	
	C Plan sponsor's name as shown on line 2a of Form 5500 ZETA ASSOCIATES INCORPORATED D Employer Identification Number (EIN) 54-1279046							
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca CIGNA GROUP INSURAN								
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
23-1503749	65498	FLX963886			01/01/2018	8	01/01/2019	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	amount of comr	missions paid		(b) To	tal amount	of fees paid		
		10036					4015	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	ersons).				
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees	were paid		
MCGRIFF INSURANCE SE	ERVICES, INC.		AIR RIDGE DR IX, VA 22033					
(b) Amount of sales ar	nd base	Fee	s and other commission	s paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
	10036							
	(a) Name a	nd address of the agent, broker,	or other person to whom	n commissi	ions or fees	were paid		
THE BENEFIT COMPANY	INC.		DX 211486 IBIA, SC 29221					
(b) Amount of sales ar	nd hase	Fee:	s and other commission	s paid				
commissions pai		(c) Amount		d) Purpose	e		(e) Organization code	
		4015 SA	ALES & SERVICES					
For Paperwork Reduction	n Act Notice	see the Instructions for Form 5	500			Scher	dule A (Form 5500) 2018	

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		For any distribution and section and the section of	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
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 corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(*) 🗀 🖫			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year			
	-	(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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines 7b and 7c(6))			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(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 Infor	mation				
		If more than one contract covers the san					
		the information may be combined for rep employees, the entire group of such indi					
Ω	Don	enefit and contract type (check all applicable boxe		arrier may be	troated do a drift for p	<u> </u>	по горога
O	Г		- —		1		al Constant
	a [Health (other than dental or vision)	b Dental	_	Vision		d X Life insurance
	е	Temporary disability (accident and sickness	f Long-term disabil	ity g	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
	L						
9	Ехре	perience-rated contracts:					
		Premiums: (1) Amount received		. 9a(1)			
		(2) Increase (decrease) in amount due but unp	oaid				
		(3) Increase (decrease) in unearned premium	reserve	9a(3)			
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid		. 9b(1)			
		(2) Increase (decrease) in claim reserves		. 9b(2)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges	(on an accrual basis)				
		(A) Commissions					
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs					
		(D) Other expenses					
		(E) Taxes		9C(1)(E)			
		(F) Charges for risks or other contingencie	9S	9C(1)(F)			
		(G) Other retention charges				0-/4\/11\	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (The		_			
	d						
		(2) Claim reserves				. 9d(2)	
	_	(3) Other reserves				. 9d(3)	
10	<u>e</u>	,	not include amount entere	a in line 9c(2)	.)	. 9e	
10	_	Ionexperience-rated contracts:				100	400000
	a	1 0 1				. 10a	100363
	b	If the carrier, service, or other organization inc retention of the contract or policy, other than r	, ,			. 10b	
	Spe	pecify nature of costs.	eported in Fart 1, line 2 abov	re, report arric	, unit		l
P	art	IV Provision of Information					
				lata Cali a di I	Λο Π	Voc	X No
		old the insurance company fail to provide any info		iete Schedule	A?	Yes	X No
12	If t	the answer to line 11 is "Yes," specify the inforn	nation not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2018

pursuant to ERISA section 103(a)(2). Inspection						•	
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and ending	12/31/2018		
A Name of plan ZETA ASSOCIATES INC	ORPORATED	INDIVIDUAL BENEFIT ACCOU	JNT		git hber (PN)	501	
C Plan sponsor's name a ZETA ASSOCIATES INCO			С	Employer I 54-1279	Identification Number 9046	(EIN)	
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca CIGNA GROUP INSURAN							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate numbersons covered at e		Policy or o	ontract year	
(b) EIN	code	identification number	policy or contract ye		(f) From	(g) To	
23-1503749	65498	OK 965514		01/	/01/2018	01/01/2019	
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. List	in line 3 the a	agents, brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
	346 0						
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all pe	rsons).			
	(a) Name	and address of the agent, broke	r, or other person to whom o	commissions	or fees were paid		
MCGRIFF INSURANCE SI	ERVICES, INC		FAIR RIDGE DR FAX, VA 22033				
(b) Amount of sales ar	nd base	Fe	ees and other commissions	paid			
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code	
	346					3	
	(a) Name	and address of the agent, broke	r, or other person to whom o	commissions	or fees were paid		
	(4)	ana aaanoo on ano agong brono	, o. cano. posco. to mis		5		
(b) Amount of sales ar	nd base	Fe	ees and other commissions	paid			
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code	
						3	

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		For any distribution and section and the section of	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
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 corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(*) 🗀 🖫			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year			
	-	(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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines 7b and 7c(6))			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art I	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group o	poses if s	such contr	acts are ex	pei	rience-rated as a unit.	Where	contrac	ts cover individual	
8	Ben	efit a	nd contract type (check all applicable boxes)										
	а	Не	ealth (other than dental or vision)	b	Dental		С		Vision		d	Life insurance	
	е	Te	emporary disability (accident and sickness)	f 🗍	Long-terr	m disability	y g	Ī	Supplemental unemp	loyment	h∏	Prescription drug	
	ιĒ	_	op loss (large deductible)		HMO cor		- 1	_	PPO contract		ıΠ	Indemnity contract	
	m	_	ther (specify) ACCIDENTAL DEATH	, 🗆			1				- Ш	,	
0			an unterel continuents.										_
9			ce-rated contracts:			Γ	00(1)	T			_		
			iiums: (1) Amount received ncrease (decrease) in amount due but unpaid			F	9a(1) 9a(2)	+			_		
			ncrease (decrease) in unearned premium res										
		` '	Earned ((1) + (2) - (3))			<u></u>				9a(4)			_
		. ,	efit charges (1) Claims paid			T T		T		5 4(1)			
			ncrease (decrease) in claim reserves			-							
			ncurred claims (add (1) and (2))							9b(3))		_
			Claims charged							9b(4))		
	C	Ren	nainder of premium: (1) Retention charges (c	n an ac	crual bas	sis)			•				
			(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			L	9c(1)(D)	1			_		
			(E) Taxes			F	9c(1)(E)	-					
			(F) Charges for risks or other contingencies.				9c(1)(F)	-			_		
			(G) Other retention charges			<u> </u>	9c(1)(G)			00/41//	□ Λ		_
			(H) Total retention		-		_			9c(1)(l			_
			Dividends or retroactive rate refunds. (These		L		L1			9c(2)			_
	d		tus of policyholder reserves at end of year: (1							9d(1)			_
		` '	Claim reserves							9d(2)			
	е	` '	Other reservesdends or retroactive rate refunds due. (Do n							9d(3) 9e	<u>'</u>		_
10			perience-rated contracts:	ot morut	ue amoui	iii entereu	111 111110 30(2	- j .)		36			
10			al premiums or subscription charges paid to o	arrier						10a		34	50
	b									104		34.	<u>) c</u>
	_	rete	e carrier, service, or other organization incurntion of the contract or policy, other than repnature of costs.							10b			_
	Spe			orteu III	Fait I, III	ie Z above	e, report an	100	int.	100			
P	art I	V	Provision of Information						1				_
11	Dic	the	insurance company fail to provide any inform	nation n	ecessary	to comple	ete Schedul	le A	Α?	Yes	X N	lo	
12	! If th	he ar	nswer to line 11 is "Yes," specify the informat	ion not p	provided.	. •		_					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

		pursuant to El	RISA section 103(a)(2).			111101011	Inspection			
For calendar plan year 20	18 or fiscal plar	year beginning 01/01/2018		and en	ding 12/3	1/2018	-			
A Name of plan ZETA ASSOCIATES INC	N) •	501								
C Plan sponsor's name as shown on line 2a of Form 5500 ZETA ASSOCIATES INCORPORATED D Employer Identification Number (EIN) 54-1279046										
		ning Insurance Contract . Individual contracts grouped as								
1 Coverage Information:										
(a) Name of insurance ca										
# N = N .	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year			
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To			
23-1503749	65498	LK 750914			01/01/2018	8	01/01/2019			
2 Insurance fee and com- descending order of the		ntion. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in			
(a) Total a	amount of comm			(b) To	tal amount	of fees paid	0.475			
		6190					2475			
3 Persons receiving com		ees. (Complete as many entries a								
		nd address of the agent, broker, o		n commiss	ions or fees	were paid				
MCGRIFF INSURANCE SI	ERVICES, INC.		IR RIDGE DR X, VA 22033							
(b) Amount of sales ar	nd base	Fees	and other commission	s paid						
commissions pa		(c) Amount	(1	d) Purpose	Э		(e) Organization code			
	6190									
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commissi	ions or fees	were paid				
THE BENEFIT COMPANY	INC.		X 211486 BIA, SC 29221							
(b) Amount of sales ar	nd base	Fees	and other commission	s paid						
commissions pa		(c) Amount	•	d) Purpose	Э		(e) Organization code			
		2475 SA	LES & SERVICE							

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		For any distribution and section and the section of	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
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 corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(*) 🗋 🕽			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year			
	-	(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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines 7b and 7c(6))			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art I	II	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	p of e	ses if	f such co	ontracts	are exp	eri	ience-rated as a uni	t. Where c	contrac	ts cover individual),
8	Bene	efit a	and contract type (check all applicable boxes)												
	а	Не	ealth (other than dental or vision)	b	D€	ental			С	٦,	Vision		d	Life insurance	
	e	Te	emporary disability (accident and sickness)	f 🗍	= Lo	ong-te	rm disa	bility	g	Ī;	Supplemental unem	ployment	h∏	Prescription drug	
	ιĒ	-	op loss (large deductible)	ιĖ	_	-	ontract	,			PPO contract	. ,		Indemnity contract	t
	느	_		, _	٦	WIO 00	Jilliaot				i i o contidot		•Ш	machinity contract	
	m [_ 0	ther (specify)												
a	Evne	rion	ce-rated contracts:												
,			niums: (1) Amount received					9:	a(1)						
			ncrease (decrease) in amount due but unpaid						1(2)						
			ncrease (decrease) in unearned premium res						1(3)						
		` '	Earned ((1) + (2) - (3))									. 9a(4)			
		. ,	nefit charges (1) Claims paid												
		(2) I	ncrease (decrease) in claim reserves					91	(2)						
		(3) I	ncurred claims (add (1) and (2))									. 9b(3)			
		(4) (Claims charged									. 9b(4)			
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accr	rual ba	asis)	_	-						
			(A) Commissions						1)(A)						
			(B) Administrative service or other fees					2.7	1)(B)						
			(C) Other specific acquisition costs					0.1	1)(C)						
			(D) Other expenses					0-/	1)(D) 1)(E)						
			(E) Taxes						1)(F)						
			(F) Charges for risks or other contingencies.(G) Other retention charges					0-7	1)(G)	-					
			(H) Total retention							<u> </u>		9c(1)(H	1)		
			Dividends or retroactive rate refunds. (These						_				,		
	d		tus of policyholder reserves at end of year: (1												
	_		Claim reserves									9d(2)			
		` '	Other reserves									9d(3)			
	е	` '	dends or retroactive rate refunds due. (Do n												
10	No	nexp	perience-rated contracts:												
	а	Tota	al premiums or subscription charges paid to o	carrier	r							. 10a			61898
	_	rete	e carrier, service, or other organization incur- ention of the contract or policy, other than rep- nature of costs.									. 10b			
	Spec	rete	Provision of Information	orted	in Pa	art I, I	line 2 at	oove, rep	ort amo	oui	nt				-
11	Did	the	insurance company fail to provide any inform	nation	n nec	cessar	ry to cor	nplete S	chedule	e A	λ? Π	Yes	X N	lo	
			nswer to line 11 is "Yes," specify the informat				-	,	,						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

		pursuant to EF	RISA section 103(a)(2).		111101011	Inspection
For calendar plan year 20°	18 or fiscal plar	year beginning 01/01/2018	and	d ending 12/	31/2018	
A Name of plan ZETA ASSOCIATES INCO	ORPORATED	NDIVIDUAL BENEFIT ACCOUNT	-	hree-digit lan number (P	PN)	501
C Plan sponsor's name a ZETA ASSOCIATES INCO		e 2a of Form 5500	D Er	nployer Identifi 54-1279046	cation Number (EIN)
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca CIGNA GROUP INSURAN						
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)) From	(g) To
23-1503749	65498	LK 962754		01/01/20	18	01/01/2019
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	commissions paid. List in lin	e 3 the agents	, brokers, and o	ther persons in
(a) Total a	amount of comr		(b) Total amount	t of fees paid	
		12781				5112
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons	s).		
	(a) Name a	nd address of the agent, broker, o	or other person to whom comm	nissions or fee	s were paid	
MCGRIFF INSURANCE SE	ERVICES, INC.		IR RIDGE DR K, VA 22033			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pai		(c) Amount	(d) Pur	oose		(e) Organization code
	12781					
	(a) Name a	nd address of the agent, broker, o	or other person to whom comm	nissions or fee:	s were paid	
THE BENEFIT COMPANY		P.O. BO	X 211486 BIA, SC 29221		,	
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pai		(c) Amount	(d) Pur	oose		(e) Organization code
		5112 SA	LES & SERVICE			

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		For any distribution and section and the section of	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
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 corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(*) 🗋 🕽			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year			
	-	(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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines 7b and 7c(6))			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art l	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individ	group ting pu	of en	es if suc	h contr	acts are	expe	erience-rated as a un	it. Where c	contract	s cover individual	
8	Ben	efit a	and contract type (check all applicable boxes)											
	а	Не	ealth (other than dental or vision)	b	Der	ntal			С	Vision		d	Life insurance	
	е	Te	emporary disability (accident and sickness)	f X	Lon	ng-term d	disabilit	v (рП	Supplemental unem	ployment	h∏	Prescription drug	
	i F	=	op loss (large deductible)	iΗ	1	O contra			- '	PPO contract	, ,	- 🗀	Indemnity contract	
	L	_		,	1	O oonina		•	``⊔	110 contract		• Ш	macming contract	
	m	_ 0	ther (specify)											
a	Evne	rion	ce-rated contracts:											_
,	•		niums: (1) Amount received					9a(1)						
			ncrease (decrease) in amount due but unpaid				-	9a(2)						
			ncrease (decrease) in unearned premium res				-	``						
		` '	Earned ((1) + (2) - (3))				<u> </u>				. 9a(4)			_
		. ,	nefit charges (1) Claims paid								, , ,			
		(2) I	ncrease (decrease) in claim reserves					9b(2)						
		(3) I	ncurred claims (add (1) and (2))								. 9b(3)			
		(4) (Claims charged								. 9b(4)			
	С	Ren	mainder of premium: (1) Retention charges (c	n an a	accru	al basis)								
			(A) Commissions					9c(1)(A						
			(B) Administrative service or other fees					9c(1)(E						
			(C) Other specific acquisition costs				F	9c(1)(C	-					
			(D) Other expenses				F	9c(1)(E	-					
			(E) Taxes				-	9c(1)(F						
			(F) Charges for risks or other contingencies (G) Other retention charges				F	0-/4\/0						
			(H) Total retention				<u> </u>				. 9c(1)(H	1)		-
			Dividends or retroactive rate refunds. (These			_			_			-		_
	d		tus of policyholder reserves at end of year: (1					Į.						-
	u		Claim reserves								. 9d(2)			_
		` '	Other reserves											_
	е	` '	dends or retroactive rate refunds due. (Do n											
10			perience-rated contracts:							,				
	а	Tota	al premiums or subscription charges paid to o	carrier.							. 10a		12780)6
	b Spe	rete	e carrier, service, or other organization incurrention of the contract or policy, other than repeature of costs.								. 10b			
P	Spe	cify r		orted ii	n Pai	rt I, line 2	2 above	e, report a	amo	unt	. 10b			
11	Dic	the	insurance company fail to provide any inform	nation	nece	essary to	comple	ete Sched	dule	A?	Yes	X No		
			nswer to line 11 is "Yes," specify the informat					200100						_

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).

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OMB No. 1210-0110

2018

		pursuant to El	RISA section 103(a)(2).			111101011	Inspection			
For calendar plan year 20	18 or fiscal plar	year beginning 01/01/2018		and end	ding 12/3	1/2018				
A Name of plan ZETA ASSOCIATES INC	N) •	501								
C Plan sponsor's name as shown on line 2a of Form 5500 ZETA ASSOCIATES INCORPORATED D Employer Identification Number (EIN) 54-1279046										
		ning Insurance Contract . Individual contracts grouped as								
1 Coverage Information:										
(a) Name of insurance ca										
	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or co	ontract year			
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To			
23-1503749	65498	TDI960459			01/01/2018	8	01/01/2019			
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	I commissions paid. List	in line 3 t	the agents,	brokers, and of	her persons in			
(a) Total a	amount of comr			(b) To	tal amount	of fees paid				
		14					0			
3 Persons receiving com		ees. (Complete as many entries a		•						
		nd address of the agent, broker, o		commissi	ons or fees	were paid				
MCGRIFF INSURANCE SI	ERVICES, INC.		IR RIDGE DR X, VA 22033							
(b) Amount of sales ar	nd base	Fees	and other commissions	paid						
commissions pa		(c) Amount	(d)) Purpose)		(e) Organization code			
	14									
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ons or fees	were paid				
		_	·			·				
(b) Amount of sales ar	nd base	Fees	and other commissions	paid						
commissions pa		(c) Amount	(d)) Purpose)		(e) Organization code			

Schedule A (Form 5500) 2018	Page 2 – 1		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
		From and other constitutions and	(-)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
, ,	<u> </u>			
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
•				
(a) Na	The standard of the stand business			
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization	
commissions paid	(0,1	(a) supers	code	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
	T		1	
(h) Amount of sales and hase		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code	
			Organization	

F	Part				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
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 corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(*) 🗋 🕽			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year			
	-	(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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines 7b and 7c(6))			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

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Department of the Treasury Internal Revenue Service

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

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2018

This Form is Open to Public Inspection.

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018	and ending 12/31/201	8
A Name of plan ZETA ASSOCIATES INCORPORATED INDIVIDUAL BENEFIT ACCOUNT	B Three-digit plan number (PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500 ZETA ASSOCIATES INCORPORATED	D Employer Identification Nu	mber (EIN)
ZETWAGGGINTEG INGGIN GINNED	54-1279046	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in complan during the plan year. If a person received only eligible indirect compensation for answer line 1 but are not required to include that person when completing the remain	nection with services rendered to the pl r which the plan received the required d	an or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compe	ensation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remaind	•	
indirect compensation for which the plan received the required disclosures (see instru	ections for definitions and conditions)	Yes X No
b If you answered line 1a "Yes," enter the name and EIN or address of each person preceived only eligible indirect compensation. Complete as many entries as needed (s	•	service providers who
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect comp	pensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect comp	pensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect comp	pensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect come	pensation
(W) Enter hame and Env or address or person who provided	you alsolosules on eligible illuliect collip	501041011

Schedule C (Form 5500) 2018	Page 2- 1
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	ho provided you disclosures on eligible indirect compensation

Page 3 -	1
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation	indirectly, \$5,000 or more in t	otal compensation
(i.e., mone	ey or anything else or			ne plan or their position with the raddress (see instructions)	plan during the plan year. (So	ee instructions).
CIGNA HE	ALTH & LIFE INSURA		(1)	,		
59-103107	1					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 38 50 13 49 56 31 62	PROVIDES CLAIM & SERVICES	0	Yes 🛛 No 🗌	Yes 🛛 No 🗌	0	Yes X No
			a) Enter name and EIN or	address (see instructions)	ı	
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐	answered "Yes" to element (f). If none, enter -0	Yes \ No \
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page	3	-	2
Page	3	-	2

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).						
(1.6., 111011	ey or arrything else or	·		r address (see instructions)	plan during the plan year. (Si	ee manuchons).
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(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		Yes No

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Part I Service Provider Information (continued)

or provides contract administrator, consulting, custodial, investment advisory, investment madvestions for (a) each source from whom the service provider received \$1,000 or more in incorprovider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	direct compensation and (b) each s	ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(a) Describe the indirect	compensation, including any
(a) Effect famile and Effy (address) of source of malifect compensation	formula used to determine	e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
		_
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	(2) 2	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

D	art II Service Providers Who Fail or Refuse to	Drovido Inform	mation		
4					
4	4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.				
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
	(a) Enter name and EIN or address of service provider (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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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)					
	No	(complete as many entries as needed)	b EIN:		
a c	Name: Position		D EIN:		
d	Addres		e Telephone:		
u	Addres	SS.	e releptione.		
Ex	planation	γ:			
а	Name:		b EIN:		
С	Positio				
d	Addres		e Telephone:		
			·		
Ex	planation	n:			
а	Name:		b EIN:		
С	Positio				
d	Addres	SS:	e Telephone:		
Explanation:					
	Mana		b EIN:		
a C	Name: Position		D EIN:		
d	Addres		e Telephone:		
u	Addres	5.	• тетернопе.		
Explanation:					
а	Name:		b EIN:		
С	Positio	n:			
d	Addres		e Telephone:		
-					
Explanation:					