Form 5500

Department of the Treesury Internal Revenue Service

Department of Labor
Employee Benefits Socurity
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 6047(e), 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

2011

Felializat deliatif directific conformation				This Form is Open to P	ubilc
	ntification Information				
For calendar plan year 2011 or fiscal		—————		/2011	
A This return/report is for:	a multlemployer plan;	∐ a multiple	e-employer plan; or		
	a single-employer plan;	a DFE (8	pecify)		
B This return/report is:	the first return/report;	the final	return/report;		
	an amended return/report;	a short p	lan year return/report (less	than 12 months).	
C If the plan is a collectively-bargain	ed plan, check here.				
D Check box if filing under:	X Form 5558;	automati	c extension;	the DFVC program;	
	special extension (enter de	scription)			
Part II Basic Plan Inform	nation-enter all requested inform	ation			
1a Name of plan DSRA BENEFIT TRUST PLAN				1b Three-digit plan number (PN)	501
				1c Effective date of pt 09/01/2009	an
2a Plan sponsor's name and addres DSRA BENEFIT TRUST	s, including room or suite number (E	Employer, if for single-	employer plan)	2b Employer Identifica Number (EIN) 26-4594868	ation
C/O BOARD OF DIRECTORS	a a			2c Sponsor's telephor number 810-629-183	
8 GRASMERE ROAD LOCKPORT, NY 14694		MERE ROAD PRT, NY 14094		2d Business code (se instructions) 525920	е
Caution: A penalty for the late or in	complete filing of this return/repo	ort will be assessed	uniess reasonable cause	is established.	-
Under penalties of perjury and other p statements and attachments, as well a	penalties set forth in the instructions, as the electronic version of this retur	I declare that I have n/report, and to the b	examined this return/report est of my knowledge and b	t, including accompanying sche cellef, it is true, correct, and cor	edules, nplete.
SIGN James ar	Laginbell	10-12-2012	JAMES L	1. HAGENBA	CH
Signature of plan adminis	trator	Date	Enter name of individual	signing as plan administrator	
sign Jemes W	Jacqueler	10-12-21-01	JAMES 1	4. HABIENMAG	1
HERE Signature of employer/pla	ın sponsor	Date	Enter name of individual	signing as employer or plan sp	onsor
SIGN Momis	Jenl.	10/15/12	Thomas	G. Landes	
Signature of DFE	(/	Date	Enter name of individual		
For Paperwork Reduction Act Notice	Wand OMR Control Numbers, see	the instructions fo	r Form 5500.	Form 550	1 (2011

v.012611

2	Form 5500 (2011)	Page 2		
DS C/ 8 (Plan administrator's name and address (if same as plan sponsor, enter "Sam SRA BENEFIT TRUST O BOARD OF DIRECTORS GRASMERE ROAD ICKPORT, NY 14094		26 3c Ac	dministrator's EIN -4594868 Iministrator's telephone umber 810-629-1835
4	If the name and/or EIN of the plan sponsor has changed since the last return/ the plan number from the last return/report:	report filed for this plan, enter the name, EIN	and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	506
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6b, 6c, and 6d).		
а	Active participants		6a	
b	Retired or separated participants receiving benefits		6b	470
С	Other retired or separated participants entitled to future benefits		6с	707
d	Subtotal. Add lines 6a, 6b, and 6c		6d	11779
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	eive benefits	6e	
f	Total. Add lines 6d and 6e		6f	11775
g	Number of participants with account balances as of the end of the plan year (complete this item)		6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested	1	6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plans complete this item)	7	
	If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4Q			
	Plan funding arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) X Trust (4) General assets of the sponsor	9b Plan benefit arrangement (check all that (1) X Insurance (2) Code section 412(e)(3) in (3) X Trust (4) General assets of the specific property	nsurano	ce contracts
10	Chark all applicable bayes in 10s and 10h to indicate which schodules are at	tached and where indicated enter the number	or attac	ched (See instructions)

b General Schedules

(1)

(2)

(3)

(4)

(5)

X

H (Financial Information)

5 A (Insurance Information)

I (Financial Information - Small Plan)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

C (Service Provider Information)

a Pension_Schedules

actuary

(1)

(2)

(3)

R (Retirement Plan Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

SCHEDULE A

(Form 5500)

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

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

2011

This Form is Open to Public

	pursuant to ERISA section	on 103(a)(2).	Inspection		
For calendar plan year 2011 or fiscal pl	an year beginning 01/01/2011	and ending 12/31/20	11		
A Name of plan DSRA BENEFIT TRUST PLAN		B Three-digit plan number (PN)	501		
C Plan sponsor's name as shown on I	ine 2a of Form 5500	D Employer Identification I	Number (EIN)		
DSRA BENEFIT TRUST		26-4594868			

Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract Part I on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

BLUE CROSS BLUE SHIELD OF MICHIGAN

-	(c) NAIC (d) Contract or		(e) Approximate number of	Policy or contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) ⊤o	
38-2069753	54291	CLUSTER 0257	5733	01/01/2011	12/31/2011	

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(b) Total amount of fees paid (a) Total amount of commissions paid 162950 87952

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

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

CATHY J.CONE

7941 KATY FREEWAY, SUITE 410 HOUSTON, TX 77024

(b) Amount of sales and base	Fees and oth		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
19301	81445		3

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

AMY A. CONE

7941 KATY FREEWAY, SUITE 410 HOUSTON, TX 77024

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
68651	81505		3

Schedule A (Form 5500)	2011	Page 2 - 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Assessed of color and book		Fees and other commissions paid	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Nis	ome and address of the agent broke	er, or other person to whom commissions or fees were paid	
(a) ite	inte and address of the agent, broke	or, or other person to minim commissions or reason are para	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	•		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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P	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	ridual contra	cts with each carrier may	be treated a	s a unit for purposes of
		this report.			4	
		rent value of plan's interest under this contract in the general account at year			5	
		rent value of plan's interest under this contract in separate accounts at year e tracts With Allocated Funds:	na		3	
U	a	State the basis of premium rates				
	-	otate the basis of premium rates 7				
	b	Premiums paid to carrier			6b	······································
	С	Premiums due but unpaid at the end of the year		\	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount				
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	a	Type of contract: (1) deposit administration (2) immedia	ate participa	tion 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				
*		(3) Interest credited during the year			12	
		(4) Transferred from separate account	The same			
		(5) Other (specify below)	. 7c(5)			
		*				
		(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6)).	г		7d	
	е	Deductions:	7-/4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below).	76(4)			
					7-15	
		(5) Total deductions		entrall of the second second second production of the second second second	7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page	4

Part III Welfare Benefit Contract Information

i Stop loss (large deductible) j HMO contract m Other (specify) Experience-rated contracts: a Premiums: (1) Amount received	47565306	_ =
e Temporary disability (accident and sickness) i Stop loss (large deductible) j HMO contract k PPO contract m Other (specify) Stop loss (large deductible) Figure 1 HMO contract Stop loss (large deductible) General Other (specify) Stop loss (large deductible) Stop loss (large loss (large loss (large loss) Stop	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	Prescription drug Indemnity contract 47565306
e	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	Indemnity contract 47565306
i Stop loss (large deductible) j HMO contract m Other (specify) Experience-rated contracts: a Premiums: (1) Amount received	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	Indemnity contract 47565306
m ☐ Other (specify) ▶ 9 Experience-rated contracts: a Premiums: (1) Amount received	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	47565306 39403198
9 Experience-rated contracts: a Premiums: (1) Amount received	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	39403198
a Premiums: (1) Amount received	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	39403198
a Premiums: (1) Amount received	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	39403198
(2) Increase (decrease) in amount due but unpaid 9a(2) (3) Increase (decrease) in unearned premium reserve 9a(3) (4) Earned ((1) + (2) - (3)) 9b(1) (2) Increase (decrease) in claim spaid 9b(1) (2) Increase (decrease) in claim reserves 9b(2) (3) Incurred claims (add (1) and (2)) 9b(2) (4) Claims charged 9c(1)(A) (A) Commissions 9c(1)(A) (B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F)	9a(4) 39517469 -114271 9b(3) 9b(4) 3715205	39403198
(3) Increase (decrease) in unearned premium reserve	39517469 -114271 9b(3) 9b(4)	39403198
(4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims paid	39517469 -114271 9b(3) 9b(4)	39403198
b Benefit charges (1) Claims paid 9b(1) (2) Increase (decrease) in claim reserves 9b(2) (3) Incurred claims (add (1) and (2)) (4) Claims charged Penaimer (1) Retention charges (on an accrual basis) (A) Commissions 9c(1)(A) (B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F)	39517469 -114271 9b(3) 9b(4)	39403198
(2) Increase (decrease) in claim reserves	-114271 9b(3) 9b(4) 3715205	
(3) Incurred claims (add (1) and (2)) (4) Claims charged C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions	9b(3) 9b(4) 3715205	
(4) Claims charged C 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 (F) Charges for risks or other contingencies 9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F)	9b(4) 3715205	
C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions	3715205	37291327
(A) Commissions 9c(1)(A) (B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F)		
(B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F)		
(C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F)		
(D) Other expenses 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F)	585917	
(E) Taxes	585917	
(F) Charges for risks or other contingencies		
()		
	1189133	
(G) Other retention charges 9c(1)(G)	2181365	
(H) Total retention	9c(1)(H)	7671620
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.		
(2) Claim reserves		2734028
(3) Other reserves	- 1121	
Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		
10 Nonexperience-rated contracts:		
a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquis		
retention of the contract or policy, other than reported in Part I, item 2 above, report amount		
Specify nature of costs		

X No

Yes

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

Part IV Provision of Information

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Insurance Information

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

OMB No. 1210-0110

Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Co	poration Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This F			This Fo	rm is Open to Public Inspection		
For calendar plan year 20	11 or fiscal pla	n year beginning 01/01/2011		and end	ding 12/31	/2011	
A Name of plan DSRA BENEFIT TRUST	PLAN			B Three-digit plan number (PN)		501	
C Plan sponsor's name a DSRA BENEFIT TRUST	s shown on lin	e 2a of Form 5500		D Employ 26-4594	er Identification 1868	on Number	(EIN)
Part I Information on a separat	on Concerr e Schedule A.	ning Insurance Contract Individual contracts grouped as	Coverage, Fees, ar	nd Comn an be repo	n issions Pr rted on a singl	ovide infor e Schedule	mation for each contract e A.
1 Coverage Information:							
(a) Name of insurance ca HARTFORD LIFE AND A							
	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or o	contract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) Fr	om	(g) To
06-0838648	70815	395285G	1301 05/01/2010			04/30/2011	
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	tal commissions paid. Lis	st in item 3	the agents, br	okers, and	other persons in
(a) Total a	amount of com	missions paid		(b) Tot	tal amount of f	ees paid	
		62356					18062
3 Persons receiving com		ees. (Complete as many entries				vec. 140 to 100	
		and address of the agent, broker			ons or fees we	ere paid	
CONE INSURANCE GRO	DUP, INC.		KATY FREEWAY, SUITE ISTON, TX 77024	= 410			
(b) Amount of sales ar	nd base	Fe	es and other commission:	s paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
31178 9031 BONUS PAID			3				
	(a) Name s	and address of the agent, broker	or other person to whom	commissi	ons or fees we	ere naid	
DONALD TRUDEAU	(a) Name a	300 F	FIRST STAMFORD PLAC MFORD, CT 06901			oro para	
(h) Amount of a lee -	nd bass	Fe	es and other commission	s paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	31178	9031 B	ONUS PAID				3
Car Danamuark Dadwatta	n Ant Notice	and OMP Control Numbers on	o the instructions for E	orm 5500		Scho	edule A (Form 5500) 2011

Schedule A (Form 5500)	2011	Page 2 - 1	
(a) Na	ame and address of the agent, bro	ker, or other person to whom commissions or fees were pai	id
// / / · · · · · · · · · · · · · · · ·		Fees and other commissions paid	(-) Oiti-
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization
(a) Na	ame and address of the agent, bro	ker, or other person to whom commissions or fees were pai	id
•			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organizatio
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	ker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organizatio
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	ker, or other person to whom commissions or fees were pai	d
(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, bro	ker, or other person to whom commissions or fees were pa	id
	•		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

_			-
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Pa	rt II					
		Where individual contracts are provided, the entire group of such individual this report.	ridual contra	icts with each carrier may	be treated as	a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Conti	racts With Allocated Funds:				
	a	State the basis of premium rates				
	b	Premiums paid to carrier		1	6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection wit	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan o	check here		
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	a	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	. 7c(5)	EDURALISM REPUTES DE DÉCAS		
					- (a)	
		(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6)).			7d	
		Deductions:	7e(1)			
		1) Disbursed from fund to pay benefits or purchase annuities during year				
		Administration charge made by carrier				
		4) Other (specify below)	7e(4)			
	,	, , outs. (specify bolotty				
		•				
		(F) Total deductions	PER INC.		70(5)	
		5) Total deductions			7e(5)	
	1	Dalarice at the end of the current year (Subtract e(3) from 0)			53 4 0 1 0	

Schedule A (Form 5500) 2011		Pag	ge 4	
Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting g the entire group of such individual contracts	group of employees of the sourposes if such contracts	are experienc	e-rated as a unit. Where con	tracts cover individual employe
efit and contract type (check all applicable boxes)			
Health (other than dental or vision)	b Dental	c 🗌	Vision	d 🛛 Life insurance
Temporary disability (accident and sickness)	f Long-term disabilit	y g ∏	Supplemental unemploymen	nt h Prescription drug
Stop loss (large deductible)	j HMO contract	k∏	PPO contract	I Indemnity contract
Other (specify)				
erience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpai	id	9a(2)		
(3) Increase (decrease) in uneamed premium re	serve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)
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)
Remainder of premium: (1) Retention charges (on an accrual basis)		A	
(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	the track the Water transfer that the water that the track to be the track to the track that the	9c(1)(D)		
(E) Taxes	was allow a survey that is also any and a survey to the survey of the su	9c(1)(E)		
(F) Charges for risks or other contingencies		9c(1)(F)		

9c(1)(H)

9c(2) 9d(1)

9d(2)

9d(3)

9e

10a

10b

519632

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision)

9 Experience-rated contracts:

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid...... (3) Increase (decrease) in unearned premium reserve..... (4) Earned ((1) + (2) - (3))..... b Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves.....

(F) Charges for risks or other contingencies (G) Other retention charges

(3) Other reserves

(H) Total retention

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

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

(2) Claim reserves

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

Part III

Pa	rt IV	Provision of Information			
11	Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

SCHEDULE A

(Form 5500)

Department of the Treasury Internal Revenue Service

Insurance Information

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

OMB No. 1210-0110

		Employee Retirement in	some occurry not or re	71 + (LI (10) (<i>'</i> '		2011
Department of Labor Employee Benefits Security Adr		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	rporation						rm is Open to Public Inspection
For calendar plan year 20	11 or fiscal pla	n year beginning 01/01/2011		and en	ding 12/31/20)11	
A Name of plan DSRA BENEFIT TRUST F	PLAN			B Three	e-digit number (PN))_	501
C Plan sponsor's name a DSRA BENEFIT TRUST				26-459			,
Part I Information on a separate	on Conceri e Schedule A.	ning Insurance Contract (Individual contracts grouped as	Coverage, Fees, a unit in Parts II and III	nd Com	missions Provorted on a single :	ide infor	mation for each contract a A.
1 Coverage Information:							
(a) Name of insurance car NATIONAL GUARDIAN L		ICE COMPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a				contract year
(b) Liii	code	identification number	policy or contrac		(f) Fron	1	(g) To
39-0493780	66583	29352	580	06	01/01/2011		12/31/2011
2 Insurance fee and common descending order of the		nation. Enter the total fees and total	al commissions paid. L	ist in item 3	the agents, brok	ers, and	other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fee	s paid	
		10279					
3 Persons receiving com	missions and f	fees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker,				paid	
FIRST PERSON, INC.			KEYSTONE CROSSIN NAPOLIS, IN 46240	G, SUITE 9	110		
(b) Amount of sales an	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	6884						3
	(a) Nama	and address of the agent, broker,	or other person to who	m commice	ions or fees wore	naid	
CONE INSURANCE GRO	10000	7941 F	KATY FREEWAY, SUIT TON, TX 77024		IONO ON IGGO WEIG	paiu	
(h) Amount of oals = ==	nd boss	Fee	s and other commission	ns paid			
(b) Amount of sales an commissions pair		(c) Amount		(d) Purpose	е		(e) Organization code
	3395						3
For Pananwork Reduction	n Act Notice :	and OMB Control Numbers see	the instructions for F	orm 5500		Sche	edule A (Form 5500) 2011

Schedule A (Form 5500)	2011	Page 2 - 1		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	Level Carrieron Control Control	
(b) Amount of sales and base	(c) Amount	(d) Purpose	(e) Organization code	
commissions paid	(c) Amount	(u) r uipose	code	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid				
(a) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Ns	ame and address of the agent broke	er, or other person to whom commissions or fees were paid		
	line and address of the agent, broke	in, or other person to whom commissions or tees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

-	- 4
₽age	

Part				
	Where individual contracts are provided, the entire group of such individual this report.	ridual contracts with each carrier ma	y be treated as a unit for	purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end	. 4	
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	nd	. 5	
6 Cor	ntracts With Allocated Funds:			
а	State the basis of premium rates			
L	Positive estate estate		- Ch	
b	Premiums paid to carrier Premiums due but unpaid at the end of the year		6b	
c d	If the carrier, service, or other organization incurred any specific costs in co			
ų.	retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan check here		
7 Cor	stracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) ☐ guaranteed investment (4) ☐ other ▶			
	_			
b	Balance at the end of the previous year		. 7b	
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year	m (A)		
	(4) Transferred from separate account			
	(b) Other (specify below)			
	(6)Total additions		7c(6)	
d	Total of balance and additions (add b and c(6)).		. 7d	
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account			
	(4) Other (specify below)	. 7e(4)		
	•			
_	(5) Total deductions		7e(5)	
f	Balance at the end of the current year (subtract e(5) from d)		. 7f	

	Schedule A (Form 5500) 2011		Pa	ge 4	_	
Part I	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts we	oup of employees of the surposes if such contracts a	are experienc	e-rated as a unit. Whe	ere contrac	ployee organizations(s), the ts cover individual employees,
8 Ben	efit and contract type (check all applicable boxes)					
a	Health (other than dental or vision)	b Dental	cx	Vision		d Life insurance
e	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	loyment	h Prescription drug
i [Stop loss (large deductible)	j HMO contract	k 🗍	PPO contract		I Indemnity contract
m	Other (specify)			•		_
į.						
9 Exp	erience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid		9a(2)			
	(3) Increase (decrease) in uneamed premium res	erve	9a(3)		7150- 17000SI	
	(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 (o	n an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1				9d(1)	
-	(2) Claim reserves	,		USS CONTRACTOR STATE	9d(2)	
	(3) Other reserves			Manager and the control of the contr	9d(3)	
е	Dividends or retroactive rate refunds due. (Do no				9e	

Part IV	Provision of Information				
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No	

Total premiums or subscription charges paid to carrier
 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount

10a

10b

413243

10 Nonexperience-rated contracts:

Specify nature of costs

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Insurance Information

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

OMB No. 1210-0110

Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 5500.			
Pension Benefit Guaranty Co	► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Fo			Form is Open to Public Inspection		
For calendar plan year 20	11 or fiscal pla	n year beginning 01/01/2011		and ending	12/31/2011	
A Name of plan DSRA BENEFIT TRUST	PLAN		В	Three-digit		501
C Plan sponsor's name a DSRA BENEFIT TRUST				26-4594868	entification Numb	
Part I Informati	on Concert te Schedule A.	ning Insurance Contract (Individual contracts grouped as a	Coverage, Fees, and a unit in Parts II and III can	Commiss be reported of	ions Provide in on a single Scheo	formation for each contract tule A.
1 Coverage Information:						
(a) Name of insurance ca						
			(e) Approximate numb	er of	Policy	or contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at en policy or contract ye	d of	(f) From	(g) To
06-0974148	88072	AGP-006038			/01/2011	12/31/2011
2 Insurance fee and com descending order of the		nation. Enter the total fees and total	al commissions paid. List in	n item 3 the a	gents, brokers, a	nd other persons in
(a) Total	amount of com	missions paid		(b) Total an	nount of fees paid	i
		8259				0
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all pers	sons).		
CONE INSURANCE GRO	And an arrangement		or other person to whom or KATY FREEWAY, SUITE 4 TON, TX 77024		or fees were paid	
(b) Amount of sales ar	nd base	Fee	s and other commissions p	aid		
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	6488					
	(a) Namo	and address of the agent, broker,	or other person to whom c	ommissions o	or fees were paid	
INSURANCE STRATEGY		6360 F	PEARL ROAD	JIIIIIII SSIOIIS C	i ices were paid	
		CLEVI	ELAND, OH 44130			
(b) Amount of sales ar		202.0	s and other commissions p			
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code
	1771					

Schedule A (Form 5500) 2011	Page 2 - 1		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(h) A		Fees and other commissions paid	110	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

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- a	u	C	~	

Part				-1-1
	Where individual contracts are provided, the entire group of such individual this report.	/idual contra	cts with each carrier may be tre	ated as a unit for purposes of
4 Ct	urrent value of plan's interest under this contract in the general account at year	end	4	
5 Cu	rrent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Co	ontracts With Allocated Funds:			
а	State the basis of premium rates			
	± 0		CI	
b	Premiums paid to carrier			
c d	Premiums due but unpaid at the end of the year		h the seculation or	
u	retention of the contract or policy, enter amount			
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
	_			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan o	check here	
7 Co	entracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participa	tion guarantee	
	(3) guaranteed investment (4) other	•		
	(/ L			
b	Balance at the end of the previous year			
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)		
	•			
ل.	(6)Total additions		7c(-
	Total of balance and additions (add b and c(6)).	1		
е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account	- (0)		
	(4) Other (specify below)	(4)		
	• ** ** ** ** ** ** ** ** ** ** ** ** **			
	(5) Total deductions			5)
	Balance at the end of the current year (subtract e(5) from d)			

_				
Р	a	α	e	4

Welfare Benefit Contract Information

Part III

9b(1) 9b(2)	Supplemental unem	ployment I	d Life insurance h Prescription drug l Indemnity contract
9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	Supplemental unem PPO contract	ployment I	h Prescription drug
9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	PPO contract	9a(4)	
9a(1) 9a(2) 9a(3) 9b(1) 9b(2)			I Indemnity contract
9a(2) 9a(3) 9b(1) 9b(2)			
9a(2) 9a(3) 9b(1) 9b(2)			
9a(2) 9a(3) 9b(1) 9b(2)			
9a(3) 9b(1) 9b(2)			
9b(1) 9b(2)			
9b(1) 9b(2)			
9b(2)		9b(3)	
		9b(3)	
		9b(3)	
		9b(4)	
9c(1)(A)			
9c(1)(B)			
9c(1)(C)			
9c(1)(D)			
9c(1)(E)			
9c(1)(F)			
9c(1)(G)			
		9c(1)(H)	
id in cash, or	credited.)	9c(2)	
		0.1/01	
(-/-/			
		10a	587644
in connection wit	th the acquisition or		00101
	9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G) id in cash, or ide benefits after	9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G) id in cash, or credited.) ide benefits after retirement ered in c(2).)	9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G) di in cash, or ☐ credited.) 10d cred in c(2).) 9c(1)(H) 9c(1)(H) 9c(2) 9d(3) 9d(3) 9e

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

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

Yes

X No

SCHEDULE A

(Form 5500)

Department of the Treasury Internal Revenue Service

Insurance Information

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

OMB No. 1210-0110

Department of Labo Employee Benefits Security Ad		File as ar	n attachme	nt to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					This Fo	rm is Open to Public Inspection		
For calendar plan year 20	11 or fiscal pla	n year beginning 01/01/201	1		and en	iding 12/	31/2011	
A Name of plan DSRA BENEFIT TRUST	PLAN				B Thre	e-digit number (PN) •	501
C Plan sponsor's name a DSRA BENEFIT TRUST					26-459	94868	ation Number	
Part I Information on a separate	on Conceri e Schedule A.	ning Insurance Contrac Individual contracts grouped a	t Covera	ge, Fees, a	nd Com	missions orted on a si	Provide informagle Schedule	mation for each contract e A.
1 Coverage Information:								
(a) Name of insurance ca		MPANY						
	(c) NAIC	(d) Contract or		pproximate nu			Policy or o	contract year
(b) EIN	code	identification number		ons covered a licy or contrac		(f)	From	(g) To
43-1420563	60025	01090		54	18	01/01/20	11	12/31/2011
2 Insurance fee and com- descending order of the		ation. Enter the total fees and t	otal commis	ssions paid. L	ist in item 3	the agents,	brokers, and	other persons in
(a) Total a	amount of com	missions paid			(b) To	otal amount	of fees paid	
		12544						
3 Persons receiving com	100000	ees. (Complete as many entrie	9/08/			328 32		
CONE INSURANCE GRO	-			EEWAY, SUIT		ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and oth	ner commission	ns paid			
commissions pa	id	(c) Amount			(d) Purpos	ose		(e) Organization code
	2040							3
	(a) Name :	and address of the agent, broke	er or other i	nerson to who	m commiss	ions or fees	were paid	
FIRST PERSON, INC.	(a) Name a	900		NE CROSSIN			were paid	3.
(b) Amount of sales ar	nd base	Ę	ees and oth	ner commission	ns paid			
commissions pa		(c) Amount			(d) Purpose	е		(e) Organization code
	10504							3
								*

Schedule A (Form 5500) 2			
(a) Nan	ne and address of the agent, b	oroker, or other person to whom commissions or fees were pair	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organizat
commissions paid	(c) Amount	(d) Purpose	code
(a) Nan	ne and address of the agent, b	proker, or other person to whom commissions or fees were pair	d
(a) Harr	o una address or the agent, o	nand, or culting person to among commissions or received a per-	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organiza
commissions paid	(c) Amount	(d) Purpose	code
(a) Non	as and address of the agent b	visitor, or other person to whom commissions or free were poi	4
(a) Nam	ie and address of the agent, b	roker, or other person to whom commissions or fees were pair	u
(b) Amount of sales and base	4/ 5000 S	Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organiza code
commissions paid			code
commissions paid		(d) Purpose	code
commissions paid (a) Nam		(d) Purpose	d
commissions paid		(d) Purpose roker, or other person to whom commissions or fees were paid	d
(a) Nam	ne and address of the agent, bu	(d) Purpose roker, or other person to whom commissions or fees were paid Fees and other commissions paid	d (e) Organiza
(a) Nam (b) Amount of sales and base commissions paid	e and address of the agent, but the agent is a second address of t	(d) Purpose roker, or other person to whom commissions or fees were paid Fees and other commissions paid	d (e) Organiza code
(a) Nam (b) Amount of sales and base commissions paid	e and address of the agent, but the agent is a second address of t	(d) Purpose roker, or other person to whom commissions or fees were paid Fees and other commissions paid (d) Purpose	d (e) Organiza code
(a) Nam (b) Amount of sales and base commissions paid	e and address of the agent, but the agent is a second address of t	(d) Purpose roker, or other person to whom commissions or fees were paid Fees and other commissions paid (d) Purpose	(e) Organiza

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P	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	vidual contra	cts with each carrier may	be treated as a	unit for purposes of		
4	4 Current value of plan's interest under this contract in the general account at year end							
		rent value of plan's interest under this contract in separate accounts at year e		5				
		tracts 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			6c			
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.			6d			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferre	d annuity					
		(3) other (specify)						
		(e) [] since (epssiny)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here				
7	_	tracts With Unallocated Funds (Do not include portions of these contracts ma						
•		_ `		tion guarantee				
	а	(,,		non guarantee				
		(3) ☐ guaranteed investment (4) ☐ other ▶						
				1	71.			
	<u>b</u>	Balance at the end of the previous year			7b			
	С	Additions: (1) Contributions deposited during the year	7 (0)					
		(2) Dividends and credits						
		(3) Interest credited during the year						
		(4) Transferred from separate account						
		(5) Other (specify below)	. 7c(5)					
		,						
	_	(6)Total additions			7c(6)			
	d ^a	Total of balance and additions (add b and c(6))			7d			
	e	Deductions:						
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		1386			
		(2) Administration charge made by carrier						
		(3) Transferred to separate account						
		(4) Other (specify below)	. 7e(4)					
		>						
		(5) Total deductions			7e(5)			
	f Balance at the end of the current year (subtract e(5) from d)				7f			

		Schedule A (Form 5500) 2011	Pa	age 4		
Pa	ırt II	Welfare Benefit Contract Information If more than one contract covers the same group of employees of information may be combined for reporting purposes if such contract the entire group of such individual contracts with each carrier may	acts are experien	ce-rated as a unit. Wh	ere contract	
8	Ben	efit and contract type (check all applicable boxes)				
	а「	Health (other than dental or vision) b Dental	сГ	Vision		d Life insurance
	e Ī	Temporary disability (accident and sickness) f Long-term di	sability or	Supplemental unem	plovment	h 🛛 Prescription drug
	i [Stop loss (large deductible)	_ =	=	,,	I Indemnity contract
	" L		ı K] FFO contract		I I indemnity contract
	m [Other (specify)				
0		erience-rated contracts:				
		Premiums: (1) Amount received	9a(1)			
	a	(2) Increase (decrease) in amount due but unpaid				
		(3) Increase (decrease) in unearned premium reserve				
		(4) Earned ((1) + (2) - (3))			9a(4)	
	b	Benefit charges (1) Claims paid	The state of the s		1	
		(2) Increase (decrease) in claim reserves				
		(3) Incurred claims (add (1) and (2))			9b(3)	
		(4) Claims charged			9b(4)	
		Remainder of premium: (1) Retention charges (on an accrual basis) -				
		(A) Commissions				
		(B) Administrative service or other fees	9c(1)(B)			
		(C) Other specific acquisition costs	9c(1)(C)			
		(D) Other expenses				
		(E) Taxes				
		(F) Charges for risks or other contingencies				
		(G) Other retention charges	9c(1)(G)			
		(H) Total retention			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These amounts were [] page 2.	aid in cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to pro	vide benefits after	retirement	9d(1)	
		(2) Claim reserves			9d(2)	
		(3) Other reserves			9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not include amount en	ntered in c(2).)		9e	
10	No	nexperience-rated contracts:				
	а	Total premiums or subscription charges paid to carrier			10a	539589

Part IV	Provision of Information				
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	No	

10b

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

Specify nature of costs >

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Service Provider Information

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

OMB No. 1210-0110

Department of Labor Employee Benefits Security Administration	▶ File as an attachment to Form 5500.		This	This Form is Open to Public		
Pension Benefit Guaranty Corporation				Inspection.		
For calendar plan year 2011 or fiscal plan	n year beginning 01/01/2011	and ending 1	2/31/2011			
A Name of plan DSRA BENEFIT TRUST PLAN		B Three-digit plan number (Pf	v))	501		
C Plan sponsor's name as shown on lin	e 2a of Form 5500	D Employer Identii	fication Number	er (EIN)		
DSRA BENEFIT TRUST		26-4594868				
Part I Service Provider Info	rmation (see instructions)					
or more in total compensation (i.e., mo plan during the plan year. If a person	dance with the instructions, to report the inf oney or anything else of monetary value) in received only eligible indirect compensation include that person when completing the rer	connection with services rendered on for which the plan received the	ed to the plan	or the person's position with the		
1 Information on Persons Rec	eiving Only Eligible Indirect Cor	mpensation				
	er you are excluding a person from the rem		received only	eligible		
	an received the required disclosures (see in					
•						
	the name and EIN or address of each personation. Complete as many entries as need		ires for the sei	vice providers who		
(b) Enter nar	ne and EIN or address of person who provi	ded you disclosures on eligible in	direct compen	sation		
DESCRIPTION OF SECURITION OF SECURITION OF SECURITION OF SECURITIES.						
(b) Enter nar	me and EIN or address of person who provi	ided you disclosure on eligible ind	direct compens	sation		
			Carrier III id (Santiby)			
(b) Enter nam	ne and EIN or address of person who provi	ded you disclosures on eligible in	direct compen	sation		
			co-medity at 200			
(b) Enter nam	ne and EIN or address of person who provi	ded you disclosures on eligible in	direct compen	sation		

Schedule C	(Form 5500) 2011 Page 2- 1
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
The graph of the comments and an example	
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
*	
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
-	
Manual Pagovaluros (1881	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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schedule	C (Form	5500) 201	1

Page 3 - 1	
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answered	l "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
-		(a) Enter name and EIN or	address (see instructions)		
MARSH AL	DVANTAGE AMERICA	1				
13-310924	8					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	666112	Yes No 🛚	Yes No		Yes No
nik salahan	NAME OF THE PROPERTY OF THE		a) Enter name and EIN or	address (see instructions)		
KREIG DEV	VAULT LLP					
35-1055087						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	173167	Yes No 🛚	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
SATERLEE 13-1810943	E,STEPHENS,BURKE	& BURKE LLP				
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	110844	Yes No X	Yes No		Yes No

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answered	l "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in	total compensation
×		(a) Enter name and EIN or	address (see instructions)		
COMERIC	A BANK					
38-047737	5					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21	NONE	9942	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
T. ROWE F	PRICE ASSOCIATES					
52-0556948	3					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28	NONE	46252	Yes 🗌 No 🛛	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
GRANT TH						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	22385	Yes No 🛚	Yes No		Yes No

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age	2		-
Sage	-3	-	13

answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in	total compensation
-			(a) Enter name and EIN or	address (see instructions)		
FIRST PE	RSON BENEFIT ADVI			,		
35-204587	9					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	152602	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
BCBS MIC	HIGAN PT D ERRP C	OMMISSIONS				
38-206975	3			8		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
70	NONE	621176	Yes No 🛚	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Part I Service Provider Information (continued)		
3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment may questions 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 amount many entries as needed to report the required information for each source.	anagement, broker, or recordkeeping direct compensation and (b) each sou	services, answer the following rce for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	(coc monaction)	Compensation
(d) Enter name and EIN (address) of source of indirect compensation		l ompensation, including any he service provider's eligibility e indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation		ompensation, including any he service provider's eligibility e indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation		Dompensation, including any he service provider's eligibility e indirect compensation.

Part II Service Providers Who Fail or Refuse to F	Provide Infor	mation
4 Provide, to the extent possible, the following information for each this Schedule.	h service provide	r who failed or refused to provide the information necessary to complete
(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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(complete as many entries as needed)	
Name:	b EIN:
Position:	
Address:	e Telephone:
Explanation:	
Name:	b EIN:
Position:	
Address:	e Telephone:
explanation:	
Name:	b EIN:
Position:	
Address:	e Telephone:
explanation:	
Nemo	b EIN:
Name: Position:	D'EIN.
Position: Address:	e Telephone:
Address.	e releptone.
	7.1.187.18.7.2.12.18.7.2.12.18.18.18.18.18.18.18.18.18.18.18.18.18.
xplanation:	
Name:	b EIN:
Position:	
Address:	e Telephone:
explanation:	

SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2011

This Form is Open to Public

Pension Benefit Guaranty Corporation	Inspection
For calendar plan year 2011 or fiscal plan year beginning 01/01/2011	and ending 12/31/2011
A Name of plan DSRA BENEFIT TRUST PLAN	B Three-digit plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500 DSRA BENEFIT TRUST	D Employer Identification Number (EIN)
Part I Asset and Liability Statement	26-4594868

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
Total noninterest-bearing cash	1a		
Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	7777184	16490028
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	7777184	16490028
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k		
	Net Assets	***		
ī	Net assets (subtract line 1k from line 1f)	11	7777184	16490028

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
(B) Participants	2a(1)(B)	19968172	
(C) Others (including rollovers)	2a(1)(C)	43979808	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		63947980
Earnings on investments:	Page 1		
(1) Interest:	100		
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	574	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		574
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	349387	
(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		349387
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	10045475	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	10040065	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		5410

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		(a) Amount	(b) Total
b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	. 2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		-100014
Other income	2c		
Total income. Add all income amounts in column (b) and enter total	2d		64203337
Expenses			
Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	. 2e(1)	44582	
(2) To insurance carriers for the provision of benefits	. 2e(2)	53611885	
(3) Other	. 2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		53656467
Corrective distributions (see instructions)	. 2f		
Certain deemed distributions of participant loans (see instructions)	. 2g		
Interest expense	. 2h		
Administrative expenses: (1) Professional fees	. 2i(1)	306396	
(2) Contract administrator fees	. 2i(2)	645893	
(3) Investment advisory and management fees	0:(0)	46252	
(4) Other	2i(4)	835485	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		1834026
Total expenses. Add all expense amounts in column (b) and enter total	. 2j		55490493
Net Income and Reconciliation			
Net income (loss). Subtract line 2j from line 2d	. 2k		8712844
Transfers of assets:			
(1) To this plan	. 21(1)		
(2) From this plan	21(2)		
art III Accountant's Opinion			
Complete lines 3a through 3c if the opinion of an independent qualified public attached.	accountant is atta	ched to this Form 5500. Comple	ete line 3d if an opinion is no
The attached opinion of an independent qualified public accountant for this plant	an is (see instruction	ons):	
(1) V Unqualified (2) Qualified (3) Disclaimer (4)	Adverse		
Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.10	3-8 and/or 103-12	(d)?	Yes X No
Enter the name and EIN of the accountant (or accounting firm) below:			
(1) Name: GAINES KRINER ELLIOTT LLP		(2) EIN: 16-0773396	
The opinion of an independent qualified public accountant is not attached be	cause:		
(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be atta	ched to the next F	orm 5500 pursuant to 29 CFR 2	2520.104-50.

Pa	rt IV Compliance Questions					
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e,	4f, 4g,	4h, 4k, 4	m, 4n, or 5.		
	103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.	Γ		T T		
•	During the plan year:		Yes	No	Ame	ount
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X		
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans					
	secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		×		
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		×		
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is					
	checked.)	4d		X		
е	Was this plan covered by a fidelity bond?	4e	X			500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X		
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X		
h	Did the plan receive any noncash contributions whose value was neither readily					
	determinable on an established market nor set by an independent third party appraiser?	4h		X		
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X			
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X			
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X		
i	Has the plan failed to provide any benefit when due under the plan?	41		Х		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m				
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n				
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year	Yes	No	Amount:		
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s) transferred. (See instructions.)), identi	fy the pla	ın(s) to which	assets or liab	ilities were
	5b(1) Name of plan(s)			5b(2) EIN(s)		5b(3) PN(s)
				(-)(-)		(-)
_						