SOMERSET CPAS, P.C. 3925 RIVER CROSSING PKWY., STE. 300 INDIANAPOLIS, IN 46240

> PAUL BEITER 150 BASTIAN ROAD ROCHESTER, NY 14623

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CLIENT'S COPY

# Form **5558**

(Rev. August 2012)

Department of the Treasury Internal Revenue Service

# **Application for Extension of Time To File Certain Employee Plan Returns**

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Information about Form 5558 and its instructions is at <a href="https://www.irs.gov/form5558">www.irs.gov/form5558</a>

OMB No. 1545-0212

File With IRS Only

Pa	art I	Identification						
A	Name of filer, plan administrator, or plan sponsor (see instructions) DELPHI SALARIED RETIREES ASSOCIATION BENEFIT TRUST			Filer's identifying number (see instr)  Employer identification number (EIN) (9 digits XX-XXXXXXX)  26-4594868				
		per, street, and room or suite no. (If a P.O. box, see instructions)  BASTIAN ROAD		Social security no	umber (	(SSN) (9 d	igits XXX-X	(-XXXX)
		or town, state, and ZIP code CHESTER, NY 14623						
	100	SINDINI, NI 14025	$\vdash$	Plan	$\overline{}$	Pla	n year ei	nding -
С		Plan name		number		ММ	DD	YYYY
_		RA BENEFIT TRUST PLAN		501		12	31	2017
Pa	art II	Extension of Time To File Form 5500 Series, and/or Form 8955-SSA						
1	L	Check this box if you are requesting an extension of time on line 2 to file the first For in Part 1, C above.	m 550	0 series return,	/repoi	rt for th	e plan lis	ted
2	l re	quest an extension of time until10/15/2018 to file Form	5500 s	series (see inst	ructio	ns).		
	No	te. A signature IS NOT required if you are requesting an extension to file Form 5500 ser	ies.					
3		•		SSA (see instru	ction	s).		
	No	te. A signature IS NOT required if you are requesting an extension to file Form 8955-SS	Α.					
	due	e application <b>is automatically approved</b> to the date shown on line 2 and/or line 3 (above date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested by than the 15th day of the third month after the normal due date.	, ,	•				
Pa	art III	Extension of Time To File Form 5330 (see instructions)						
4	I re	quest an extension of time until to file Form	5330.					
		u may be approved for up to a 6 month extension to file Form 5330, after the normal du	e date	of Form 5330.				
		er the Code section(s) imposing the tax						
		er the payment amount attached			b			
		excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendmen	t date		С			
5	Sta	te in detail why you need the extension:						
		nalties of perjury, I declare that to the best of my knowledge and belief, the statements I am authorized to prepare this application.	made	on this form a	e true	e, corre	ct, and c	omplete,
Sig	natur	e <b>▶</b>		Date <b>&gt;</b>				
						F	orm <b>555</b>	<b>8</b> (Rev. 8-2012)



3925 River Crossing Pkwy Suite 300 PO Box 40368 Indianapolis, IN 46240 tel: 317.472.2200 / 800.469.7206 fax: 317.208.1200 somersetcpas.com

October 15, 2018

Paul Beiter 150 Bastian Road Rochester, NY 14623

Dear Paul:

Enclosed is 2017 Form 5500 for DSRA BENEFIT TRUST PLAN, Plan Number 501.

This return has been prepared for electronic filing. Please sign, date, and retain an original of the return for the plan's records. We will submit your electronic return. Do NOT mail the paper copy of your return to EFAST2.

Please review the return for completeness and accuracy.

Also enclosed is the Summary Annual Report for the plan. The Employee Retirement Income Security Act of 1974 (ERISA) and Department of Labor regulations require the information enclosed herein to be given to each participant and beneficiary receiving benefits after the close of the plan year. This information should be delivered by hand or first class mail.

We sincerely appreciate the opportunity to serve you. Please contact us if you have any questions concerning the return.

Sincerely,

Xiaolin Shi, CPA SOMERSET CPAs, P.C.

# 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

2017

This Form is Open to Public Inspection

Part I Annual Report Identification I	nformation		•					
For calendar plan year 2017 or fiscal plan year beg	inning 01/01/	2017 and ending	g 12/31/2017					
A This return/report is for: a multiemployer	report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of							
_	participating employer information in accordance with the form instr.)							
a single-employe	erplan 📗 a	DFE (specify)	_					
B This return/report is:	eport U th	e final return/report						
an amended ret	-	short plan year return/rep	ort (less than 12 months)					
If the plan is a collectively-bargained plan, check h	ere		▶∐					
D Check box if filing under:  Form 5558	∐ au	itomatic extension	the DFVC program					
	n (enter description)							
Part II Basic Plan Information - enter a	Il requested information		-					
1a Name of plan			1b Three-digit	E01				
DSRA BENEFIT TRUST PLAN		•	plan number (PN)	501				
			1c Effective date of plan 09/01/2009					
2a Plan sponsor's name (employer, if for a single-employer	plan)		2b Employer Identification No	umber (EIN)				
Mailing address (include room, apt., suite no. and street	,		26-4594868					
City or town, state or province, country, and ZIP or forei		•						
DELPHI SALARIED RETIREES AS	SOCIATION BE	NEFIT TRUST	585-424-2079	······································				
			2d Business code (see instru 525920	ctions)				
150 BASTIAN ROAD			323320					
150 DADITAN KOAD								
ROCHESTER NY	14623							
TO CITED THE	11023							
Caution: A penalty for the late or incomplete filing of	f this return/report wil	be assessed unless rea	sonable cause is established.					
Under penalties of perjury and other penalties set forth in the instructions	, I declare that I have examined	this return/report, including accom	panying schedules, statements and attachr	nents, as well				
as the electronic version of this return/report, and to the best of my know	ledge and belief, it is true, corre	ct, and complete.						
SIGN Paul Berton	10/15/18	PAUL BEITER						
HERE Signature of plan administrator	Date /	Enter name of individua	l signing as plan administrator					
SIGN HERE								
Signature of employer/plan sponsor	Date	Enter name of individua	l signing as employer or plan spo	onsor				
SIGN HERE								
Signature of DFE	Date	Enter name of individua						
For Paperwork Reduction Act Notice, see the Instru	ctions for Form 5500.		Form	1 5500 (2017) v. 170203				

718401 10-04-17

3a	Plan administrator's name and address X Same as Plan Sponsor		<b>3b</b> Administrator's EIN			
			3c Administrator's telephone number			
4	If the name and/or EIN of the plan sponsor or the plan name has chang	ed since the last return/repo	rt filed for this	olan,	4b EIN	
	enter the plan sponsor's name, EIN, the plan name and the plan number	er from the last return/report:				
а	Sponsor's name				<b>4d</b> PN	
С	Plan Name					
				-	1 512	
<u>5</u>	Total number of participants at the beginning of the plan year			5	4,543	
O	Number of participants as of the end of the plan year unless otherwise	stated (welfare plans comple	ete only lines			
2	6a(1), 6a(2), 6b, 6c, and 6d).			6a(1)	4,543	
	(1) Total number of active participants at the beginning of the plan year (2) Total number of active participants at the end of the plan year			6a(2)	5,308	
	Retired or separated participants receiving benefits			6b	0	
	Other retired or separated participants receiving benefits			6c	0	
	Subtotal. Add lines <b>6a(2), 6b,</b> and <b>6c</b>			6d	5,308	
e	Deceased participants whose beneficiaries are receiving or are entitled	to receive benefits		6e	.,	
f	Total. Add lines <b>6d</b> and <b>6e</b>			6f		
g	Number of participants with account balances as of the end of the plan					
	complete this item)	• • •	=	6g		
h	Number of participants who terminated employment during the plan ye					
	less than 100% vested			6h		
7	Enter the total number of employers obligated to contribute to the plan	(only multiemployer plans co	omplete	_		
_	this item)			7		
b	If the plan provides pension benefits, enter the applicable pension feature of the plan provides welfare benefits, enter the applicable welfare feature $4B\ 4D\ 4E\ 4Q$					
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arranger	nent (check all	that app	oly)	
	(1) X Insurance	(1) X Insurance				
	(2) Code section 412(e)(3) insurance contracts	(2) Code section	n 412(e)(3) insu	ırance c	contracts	
	(3) X Trust	(3) X Trust				
40	(4) General assets of the sponsor		ets of the spon			
10	Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)	are attached, and, where in	dicated, enter t	he numl	ber attached.	
а	Pension Schedules	b General Schedules				
	(1) R (Retirement Plan Information)	(1) 🛛 H	(Financial Inf	ormatio	n)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	(Financial Inf	ormatio	n - Small Plan)	
	Purchase Plan Actuarial Information) - signed by the plan	(3) X _ 5 A	(Insurance In	formation	on)	
	actuary	(4) X C	(Service Prov	ider Info	ormation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) X D	(DFE/Particip	ating Pl	an Information)	
	Information) - signed by the plan actuary	(6) 📙 G	(Financial Tra	ansactio	n Schedules)	

Part I	II Form M-1 Compliance Information (to be completed by welfare benefit plans)									
	11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29									
C	FR 2520.101-2.) Yes 🗓 No									
If	"Yes" is checked, complete lines 11b and 11c.		_							
<b>11b</b> Is	the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)	Yes	No							
11c Er	nter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 For	m M-1 annual	report,							
er	nter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing	requirements.	(Failure							
to	to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)									
Re	eceipt Confirmation Code									

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

For calendar plan year 2017 or fiscal plan year beginning

**Insurance Information** 

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

and ending

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

01/01/2017

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

12/31/2017

A Name of plan DSRA BENEFIT TRUST PLAN						ree-digit an number (PN)	501			
C Plan sponsor's name as shown on line 2a of Form 5500 DELPHI SALARIED RETIREES ASSOCIATION BENEFIT TRUST  D Employer Identification Number 26-4594868										
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.										
1 Coverage Informat	tion:									
(a) Name of insurance	e carrier									
BLUE CROSS	BLUE SH	IELD OF MICHIG	AN							
(b) EIN	(c) NAIC	(d) Contract or		ate number of perso		Policy or co	ontract year			
(5) =	code	identification number	covered at end	of policy or contract	year	(f) From	<b>(g)</b> To			
38-2069753	54291	278939		31	93	01/01/2017	12/31/2017			
2 Insurance fee and in descending order		nformation. Enter the total fe	es and total commis	sions paid. List in lir	ne 3 th	ne agents, brokers, a	nd other persons			
(a)	Total amount o	of commissions paid		<b>(b)</b> To	tal am	ount of fees paid				
			0				0			
3 Persons receiving	commissions	and fees. (Complete as many	entries as needed	to report all persons	s).					
	(a) Name a	nd address of the agent, bro	ker, or other persor	to whom commission	ons o	r fees were paid				
(b) Amount of sale			Fees and othe	commissions paid			(e) Organization			
commissions	s paid	(c) Amount	(c) Amount (d) Purp				code			
	(a) Name a	nd address of the agent, bro	ker, or other persor	to whom commissi	ons o	fees were paid				
(b) Amount of sales and base Fees and other commissions paid commissions paid					(e) Organization					
CONTINUESION	- Paid	(c) Amount	· · · · · · · · · · · · · · · · · · ·	(d) Purpos	se		code			

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
<b>(b)</b> Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
			1	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, 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) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	

Р	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of s purposes of this report.	uch individual contracts with each	n carrier ma	y be treated as a unit for
4	Current value of plan's interest under this contract in the general accoun	t at year end		
5	Current value of plan's interest under this contract in separate accounts	at year end	5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
	Premiums paid to carrier		6b	
C	Premiums due but unpaid at the end of the year		6c	
C	If the carrier, service, or other organization incurred any specific costs			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defer	rred annuity		
	(3) dther (specify)			
_			_	1
<u>_f</u>	If contract purchased, in whole or in part, to distribute benefits from a			
7	Contracts With Unallocated Funds (Do not include portions of these co		•	
а	Type of contract: (1) deposit administration (2)	immediate participation guara	ntee	
	(3) Uguaranteed investment (4)	☐ other ►		
			76	
	Balance at the end of the previous year		7b	
C	Additions: (1) Contributions deposited during the year		-	
	(2) Dividends and credits	` <del>                                    </del>	_	
	(3) Interest credited during the year	· <del>                                    </del>	_	
	(4) Transferred from separate account			
	(5) Other (specify below)	70(3)		
	(6) Total additions		7c(6)	0
C	• _ · · · · · · · · · · · · · · · · · ·		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)			
	<b>&gt;</b>			
	(5) Total deductions		7e(5)	0
f			7f	

_					
	Welfare Benefit Contract Information If more than one contract covers the same group of employee organization(s), the information may be combin as a unit. Where contracts cover individual employees, the treated as a unit for purposes of this report.	ed for reporti	ng purposes if such	contracts are	e experience-rated
8	Benefit and contract type (check all applicable boxes)  a	-	c X Vision g Supplementa k X PPO contrac		d Life insurance  h X Prescription drug Indemnity contract
9	Experience-rated contracts:				
а	Premiums: (1) Amount received	9a(1)	14,51	2,919	
	(2) Increase (decrease) in amount due but unpaid		•		
	(3) Increase (decrease) in unearned premium reserve	0 (0)			
	, , , , , , , , , , , , , , , , , , , ,			9a(4)	14,512,919
<b>L</b>	(4) Earned ((1) + (2) - (3))		11,82		14,312,313
D	Benefit charges: (1) Claims paid	<del>::-</del>			
	(2) Increase (decrease) in claim reserves			8,180	11 600 710
	(3) Incurred claims (add (1) and (2))			9b(3)	11,698,718
	(4) Claims charged			9b(4)	11,698,718
С	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees	9c(1)(B)	94	2,053	
	(C) Other specific acquisition costs	9c(1)(C)			
	(D) Other expenses	9c(1)(D)			
	(E) Taxes	9c(1)(E)	23	3,925	
	(F) Charges for risks or other contingencies			9,568	
	(G) Other retention charges	<del>- ::::::</del>	-	,	
	(H) Total retention	. ,,,,		9c(1)(H)	1,555,546
	(2) Dividends or retroactive rate refunds. (These amounts were			9c(2)	
А	Status of policyholder reserves at end of year: (1) Amount held to pro	•		9d(1)	
u				9d(2)	575,336
	(2) Claim reserves			_ ` _	373,330
_	(3) Other reserves			9d(3)	
	Dividends or retroactive rate refunds due. (Do not include amount en	itered in line 9	9c(2).)	9e	
	Nonexperience-rated contracts:				
	Total premiums or subscription charges paid to carrier			10a	
b	,,				
	the acquisition or retention of the contract or policy, other than report	rted in Part I,	line 2		
	above, report amount			10b	
S	pecify nature of costs				

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

Department of the Treasury Internal Revenue Service

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

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

File as an attachment to Form 5500.

► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		P					•
For calendar plan year 20	17 or fiscal plan	/ear beginning 01/01	/201	7 and ending	)	12/31/2017	
A Name of plan					<b>B</b> Th	ree-digit	
DSRA BENEFI	T TRUST	PLAN			pla	an number (PN)	501
•		n line 2a of Form 5500			<b>D</b> En	nployer Identification	
		TIREES ASSOCIAT				26-459486	
		erning Insurance Con					
4		Schedule A. Individual contr	acts grou	iped as a unit in Parts II and	III can	be reported on a sing	gie Schedule A.
Coverage Information	tion:						
(a) Name of insurance	e carrier						
EXPRESS SCR	TPTS IN	IC.					
	(c) NAIC	(d) Contract or	(e)	Approximate number of pers	ons	Policy or co	ontract vear
(b) EIN	code	identification number		covered at end of policy or contract y		(f) From	<b>(g)</b> To
						,,	(6)
43-1420563	60025				945	01/01/2017	12/31/2017
2 Insurance fee and	commission in	formation. Enter the total fee	s and tot	al commissions paid. List in	line 3 th	ne agents, brokers, a	nd other persons
in descending ord	er of the amour	nt paid.					
(a) <sup>¬</sup>	Total amount of	commissions paid		(b) T	otal am	ount of fees paid	
		28,	348				0
3 Persons receiving	commissions a	nd fees. (Complete as many	entries a	s needed to report all perso	ns).		
	(a) Name an	d address of the agent, brok	er, or oth	ner person to whom commis	sions o	fees were paid	
MARSH	TMII DD TI	713					
12421 MERED	T.H DKT/		. 0				
URBANDALE		IA 5039	8				
(b) Amount of sale	es and base		Fees	and other commissions paid	d		(e) Organization
commission	s paid	(c) Amount		(d) Purpo	286	code	
		(c) Amount		(d) i dipi	J3C		
	28,348						3
	(a) Name an	d address of the agent, brok	er, or oth	ner person to whom commis	sions o	r fees were paid	
	(4,7)	<u>a aaa, 555 5, 1,15 ago, 1, 5,15.</u>	,	p			
(b) Amount of sale	e and base		F		1		(e)
commission			-ees	and other commissions paid	ı 		Organization
COMMINISSION	5 paid	(c) Amount		(d) Purpe	ose	code	

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

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
<b>(b)</b> Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
			1	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, 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) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	

Р	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of s purposes of this report.	uch individual contracts with each	n carrier ma	y be treated as a unit for
4	Current value of plan's interest under this contract in the general accoun	t at year end		
5	Current value of plan's interest under this contract in separate accounts	at year end	5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
	Premiums paid to carrier		6b	
C	Premiums due but unpaid at the end of the year		6c	
C	If the carrier, service, or other organization incurred any specific costs			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defer	rred annuity		
	(3) dther (specify)			
_			_	1
<u>_f</u>	If contract purchased, in whole or in part, to distribute benefits from a			
7	Contracts With Unallocated Funds (Do not include portions of these co		•	
а	Type of contract: (1) deposit administration (2)	immediate participation guara	ntee	
	(3) Uguaranteed investment (4)	☐ other ►		
			76	
	Balance at the end of the previous year		7b	
C	Additions: (1) Contributions deposited during the year		-	
	(2) Dividends and credits	` <del>                                    </del>	_	
	(3) Interest credited during the year	· <del>                                    </del>	_	
	(4) Transferred from separate account			
	(5) Other (specify below)	70(3)		
	(6) Total additions		7c(6)	0
C	• _ · · · · · · · · · · · · · · · · · ·		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)			
	<b>&gt;</b>			
	(5) Total deductions		7e(5)	0
f			7f	

P	art I	Welfare Benefit Contract Information				
		If more than one contract covers the same group of em	inlovees of the	same employer(s) o	r members of t	he same
		employee organization(s), the information may be comb				
		as a unit. Where contracts cover individual employees,	•	0		•
		treated as a unit for purposes of this report.	5 1			,
8	Por	efit and contract type (check all applicable boxes)				
0	a	Health (other than dental or vision)    Health (other than dental or vision)		<b>c</b> ∏ Vision		d  Life insurance
	e e	-		<b>H</b>	_1	<b>—</b>
	i	and the state of t	rm disability	- H	al unemployme	. H
	m	Stop loss (large deductible)	ontract	k PPO contrac	ct	Indemnity contract
_		Other (specify)				
9		erience-rated contracts:	0 (4)			
а		miums: (1) Amount received				
		Increase (decrease) in amount due but unpaid	- (-)			
	٠,	Increase (decrease) in unearned premium reserve				
		Earned ((1) + (2) - (3))			9a(4)	
b		efit charges: (1) Claims paid				
		Increase (decrease) in claim reserves				
	(3)	Incurred claims (add (1) and (2))			9b(3)	
	(4)	Claims charged			9b(4)	
С	Rer	nainder of premium: (1) Retention charges (on an accrual basis	·			
		(A) Commissions				
		(B) Administrative service or other fees				
		(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	<u></u>	<u></u>	9c(1)(H)	
	(2)	Dividends or retroactive rate refunds. (These amounts were	paid in cash,	or 🔲 credited.)	9c(2)	
d	Sta	tus of policyholder reserves at end of year: (1) Amount held to p	provide benefits	after retirement	9d(1)	
	(2)	Claim reserves			9d(2)	
	(3)	Other reserves			9d(3)	
е		dends or retroactive rate refunds due. (Do not include amount			9e	
10	Noi	nexperience-rated contracts:				
а	Tot	al premiums or subscription charges paid to carrier			10a	1,207,264
b		e carrier, service, or other organization incurred any specific co				
		acquisition or retention of the contract or policy, other than rep				
	abo	ve, report amount			10b	
S		y nature of costs				

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

Department of the Treasury Internal Revenue Service

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

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

► File as an attachment to Form 5500.

► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		Pu	Suarit to	LI 110/ 36011011 100(a)(2)		1 45	io inopeodon
For calendar plan year 20	17 or fiscal plan	year beginning 01/03	1/201	7 and e	nding	12/31/2017	
A Name of plan					Вт	nree-digit	
DSRA BENEFI	T TRUST	PLAN			pl	an number (PN)	501
C Plan anangar'a na	mo oo ohown o	on line 2a of Form 5500			D E	mployer Identification	Number (EIN)
		FIREES ASSOCIA:	rion	BENEFIT TRUS		26-459486	
		cerning Insurance Cor					
4	<u>.</u>	Schedule A. Individual cont	racts gro	iped as a unit in Parts II	and III can	be reported on a sing	le Schedule A.
1 Coverage Informa	tion:						
(a) Name of insurance	e carrier						
HARTFORD LI	FE AND	ACCIDENT					
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or		Approximate number of		Policy or co	
	code	identification number	covered at end of policy or contra		ntract year	(f) From	<b>(g)</b> To
06-0838648	70815				1005	01/01/2017	12/31/2017
_		formation. Enter the total fee	es and to	al commissions paid. Li		-	
in descending ord	er of the amou	nt paid.					
(a) <sup>-</sup>	Total amount o	f commissions paid			(b) Total an	nount of fees paid	
3 5			0				0
3 Persons receiving		and fees. (Complete as many nd address of the agent, bro		<u> </u>		r foos woro paid	
	(a) Name a	id address of the agent, bro	Kei, oi oti	lei person to whom con	11113310113 0	i lees were paid	
		_					
(b) Amount of sale	es and base		Fees	and other commissions	paid		(e)
commission	s paid	(c) Amount		(d) F	Purpose		Organization code
		(c) Amount		(u) i	ирозс		
							•
	(a) Name a	nd address of the agent, bro	ker, or otl	ner person to whom con	nmissions o	r fees were paid	
(la) A							(e)
(b) Amount of sale commission			Fees	and other commissions	paid		Organization
COMMINISSION	o paiu	(c) Amount		(d) F	Purpose		code
		1					

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

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
	•		•	
(a) Name ar	nd address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nama ar	ad addraga of the agent by	okov ov othov noven to whom commissions ov foce wave noid		
(a) Name an	id address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and				
(a) Name ar	id address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
	•		•	
(a) Name ar	nd address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
Commissions paid	(c) Amount (d) Purpose		code	
	1	1		

Р	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of s purposes of this report.	uch individual contracts with each	n carrier ma	y be treated as a unit for
4	Current value of plan's interest under this contract in the general accoun	t at year end		
5	Current value of plan's interest under this contract in separate accounts	at year end	5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
	Premiums paid to carrier		6b	
C	Premiums due but unpaid at the end of the year		6c	
C	If the carrier, service, or other organization incurred any specific costs			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defer	rred annuity		
	(3) dther (specify)			
_			_	1
<u>_f</u>	If contract purchased, in whole or in part, to distribute benefits from a			
7	Contracts With Unallocated Funds (Do not include portions of these co		•	
а	Type of contract: (1) deposit administration (2)	immediate participation guara	ntee	
	(3) Uguaranteed investment (4)	☐ other ►		
			76	
	Balance at the end of the previous year		7b	
C	Additions: (1) Contributions deposited during the year		-	
	(2) Dividends and credits	` <del>                                    </del>	_	
	(3) Interest credited during the year	· <del>                                    </del>	_	
	(4) Transferred from separate account			
	(5) Other (specify below)	70(3)		
	(6) Total additions		7c(6)	0
C	• _ · · · · · · · · · · · · · · · · · ·		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)			
	<b>&gt;</b>			
	(5) Total deductions		7e(5)	0
f			7f	

Pa	art III	Welfare Benefit Contract Information				
		If more than one contract covers the same group of en	nployees of the s	same employer(s) o	r members of	the same
		employee organization(s), the information may be com-	bined for reporting	ng purposes if such	contracts are	experience-rated
		as a unit. Where contracts cover individual employees	, the entire group	of such individual	contracts with	each carrier may be
		treated as a unit for purposes of this report.				
8	Popofit	and contract type (check all applicable boxes)				
•		Health (other than dental or vision)		<b>c</b> Vision		<b>d</b> Life insurance
		emporary disability (accident and sickness)	orm disability	<del>     </del>	al unemploym	. H
	. H	· · · · · · · · · · · · · · · · · · ·	•	R PPO contract		Indemnity contract
		Stop loss (large deductible)  Other (specify) ► MEDICARE SUPPLEMENT	ontract	N   PPO contrac	JI.	· 🔲 indemnity contract
9		•				
_	•	ence-rated contracts:	0-(4)			
а		ms: (1) Amount received	2 (2)			
		crease (decrease) in amount due but unpaid				
		crease (decrease) in unearned premium reserve			1 0 (0)	
_		arned ((1) + (2) - (3))			9a(4)	
b		charges: (1) Claims paid				
		crease (decrease) in claim reserves				
	(3) In	curred claims (add <b>(1)</b> and <b>(2)</b> )			9b(3)	
	(4) C	aims charged			9b(4)	
С	Remair	nder of premium: (1) Retention charges (on an accrual basis				
	(A	) Commissions	9c(1)(A)			
	(B	) Administrative service or other fees	9c(1)(B)			
	(C	) Other specific acquisition costs	9c(1)(C)			
	(D		6 (1)(5)			
	(E					
	(F					
	(G					
	•	) Total retention			9c(1)(H)	
	-	vidends or retroactive rate refunds. (These amounts were		or Credited.)	9c(2)	
d		of policyholder reserves at end of year: (1) Amount held to	_		9d(1)	
		aim reserves	•		9d(2)	
		ther reserves			9d(3)	
е		nds or retroactive rate refunds due. (Do not include amount			9e	
10		perience-rated contracts:	CITEORGA III IIIIO C	, o(=j.)	1 33	
a		remiums or subscription charges paid to carrier			10a	1,434,132
		arrier, service, or other organization incurred any specific c				
		quisition or retention of the contract or policy, other than re				
			•	III 1 <del>C</del> Z	10b	
c.					100	
اد	pecity the	ature of costs				
		Duradalari ad Informati				
	art IV	Provision of Information				
11		insurance company fail to provide any information necess		Schedule A?	<u> </u>	Yes X No
12	If the a	nswer to line 11 is "Yes," specify the information not provid	ded. 🕨			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

For calendar plan year 2017 or fiscal plan year beginning

**Insurance Information** 

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

► File as an attachment to Form 5500.

► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

and ending

01/01/2017

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

12/31/2017

A Name of plan DSRA BENEFI	N Name of plan OSRA BENEFIT TRUST PLAN						501	
DELPHI SALA	RIED RE'	on line 2a of Form 5500 PIREES ASSOCIA				mployer Identification 26-459486	8	
contract	t on a separate			Coverage, Fees, and ( ouped as a unit in Parts II and				
1 Coverage Informa	tion:							
(a) Name of insurance	e carrier							
METROPOLITA	N LIFE	INSURANCE COMP	ANY					
(b) EIN	(c) NAIC	(d) Contract or		Approximate number of pers		Policy or co	ontract year	
(5) EIIV	code	identification number	cover	red at end of policy or contra	ct year	(f) From	<b>(g)</b> To	
13-5581829	65978	149752		5	308	01/01/2017	 12/31/2017	
2 Insurance fee and in descending ord			es and to	rtal commissions paid. List in	line 3 t	<b>-</b>		
(a) <sup>-</sup>	Total amount o	f commissions paid		(b) 1	otal an	nount of fees paid		
<u> </u>			0				0	
3 Persons receiving				as needed to report all perso ther person to whom commis		ur foos wore paid		
	(a) Name a	id address of the agent, bro	ikei, oi oi	iner person to whom commis	510115 C	i lees wele palu		
(b) Amount of sale			Fees	s and other commissions pai	d		(e) Organization	
commission	s paid	(c) Amount		<b>(d)</b> Purp	ose		code	
	(a) Name a	nd address of the agent, bro	ker, or ot	ther person to whom commis	sions c	r fees were paid		
(b) Amount of sale			Fees	s and other commissions pai	d		(e) Organization	
commission	s paid	(c) Amount		<b>(d)</b> Purp	ose		code	

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

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
			•	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
			•	
(a) Name an	d address of the agent, bro	oker, 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) Name an	d address of the agent, bro	oker, 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	
		·		

P	Part II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of s purposes of this report.	such individual contracts with eacl	n carrier may	y be treated as a unit for
<u>4</u>	Current value of plan's interest under this contract in the general accour	nt at year end	4	
<u>5</u>	Current value of plan's interest under this contract in separate accounts	at year end	5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6c	
C	If the carrier, service, or other organization incurred any specific costs	in connection with		
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Properties Type of contract: (1) individual policies (2) group defe	erred annuity		
	(3) other (specify)			
_				İ
<u>_f</u>	If contract purchased, in whole or in part, to distribute benefits from a			
7	Contracts With Unallocated Funds (Do not include portions of these c			
а	Type of contract: (1) deposit administration (2)	immediate participation guara	ntee	
	(3) Uguaranteed investment (4)	other		
<b>L</b>			7b	
	Balance at the end of the previous year		170	
·	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)			
	(b) Other (specify below)	13(3)		
	(6) Total additions		7c(6)	0
C	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account			
	(4) Other (specify below)			
	<b>&gt;</b>			
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d	)	7f	

_					
	Welfare Benefit Contract Information If more than one contract covers the same group of employee organization(s), the information may be combin as a unit. Where contracts cover individual employees, the treated as a unit for purposes of this report.	ed for reporti	ng purposes if such	contracts are	e experience-rated
8	Benefit and contract type (check all applicable boxes)  a	-	c Vision g Supplementa k PPO contract		ent  d X Life insurance Prescription drug Indemnity contract
9	Experience-rated contracts:				
а	Premiums: (1) Amount received	9a(1)	3.10	1,385	
-	(2) Increase (decrease) in amount due but unpaid	9a(2)			
	(3) Increase (decrease) in amount due but dripaid	- :-:			
				00(4)	3,101,385
<b>L</b>	(4) Earned ((1) + (2) - (3))			<b>9a(4)</b> 0,478	3,101,303
D	Benefit charges: (1) Claims paid				
	(2) Increase (decrease) in claim reserves			6,044	2 206 522
	(3) Incurred claims (add (1) and (2))			9b(3)	2,386,522
	(4) Claims charged			9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees	9c(1)(B)			
	(C) Other specific acquisition costs	9c(1)(C)			
	(D) Other expenses	9c(1)(D)	23	0,445	
		9c(1)(E)		7,241	
	(E) Taxes			4,774	
		<del>- 1.11-1</del>		2,403	
	(G) Other retention charges	. ,,,,			714,863
	(H) Total retention			9c(1)(H)	714,003
	(2) Dividends or retroactive rate refunds. (These amounts were			9c(2)	
a	Status of policyholder reserves at end of year: (1) Amount held to pro		r	9d(1)	002 840
	(2) Claim reserves			9d(2)	823,748
	(3) Other reserves			9d(3)	3,214,605
	Dividends or retroactive rate refunds due. (Do not include amount en	tered in line 9	9c(2).)	9e	
10	Nonexperience-rated contracts:				
а	Total premiums or subscription charges paid to carrier			10a	
b	If the carrier, service, or other organization incurred any specific cost		T T		
	the acquisition or retention of the contract or policy, other than repor				
	above, report amount			10b	
S	pecify nature of costs				
اح	Joony Hataro or Jooto				

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

Department of the Treasury Internal Revenue Service

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

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

File as an attachment to Form 5500.

► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 20	)17 or fiscal plan	year beginning $01/0$	1/201	.7 and	d ending		12/31/2017	
A Name of plan DSRA BENEFI	T TRUST	PIAN					ree-digit n number (PN)	501
	1 111021					pia	arriamoer (r 11)	301
		on line 2a of Form 5500 FIREES ASSOCIA	TION	BENEFIT TRU		<b>D</b> Em	ployer Identification 26-459486	
		cerning Insurance Co Schedule A. Individual cont		•				
1 Coverage Informa	tion:		-					
(a) Name of insurance	e carrier							
• •		LIFE INSURANCE	COMP	ANY				
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e)	Approximate number	of perso	ns	Policy or co	ntract year
(b) LIN	code	identification number	cover	ed at end of policy or o	contract	year	(f) From	<b>(g)</b> To
36-0883760	68381	GL 150478			14	153	01/01/2017	12/31/2017
2 Insurance fee and in descending ord		formation. Enter the total fe nt paid.	es and to	tal commissions paid.	List in li	ne 3 th	e agents, brokers, ar	nd other persons
(a) <sup>-</sup>	Total amount o	f commissions paid			<b>(b)</b> To	tal am	ount of fees paid	
			0					0
3 Persons receiving		and fees. (Complete as man					fanaana maid	
	(a) Name a	nd address of the agent, bro	oker, or ot	ner person to whom c	ommiss	ions or	tees were paid	
(b) Amount of sale	es and base		Fees	and other commissio	ons paid			(e)
commission	s paid	(c) Amount			d) Purpo			Organization code
		(C) Amount		(u	i) Furpo	5 <del>C</del>		
						-		
	(a) Name a	nd address of the agent, bro	ker, or ot	her person to whom c	commiss	ions or	fees were paid	
(b) Amount of sales and base Fees and other commissions paid								
commission	s paid	(c) Amount		(d	d) Purpo	se		code

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(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
/ XXI				
(a) Name an	d address of the agent, bro	oker, 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) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
	T		(a)	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
Continuesions paid	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
<b>(b)</b> Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
Commissions paid	(c) Amount	(d) Purpose	code	
	1		İ	

Р	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of supurposes of this report.	uch individ	ual contracts with each	carrier m	nay be treated as a unit for
		t value of plan's interest under this contract in the general account				
5	Current	t value of plan's interest under this contract in separate accounts	at year end		. 5	
6	Contrac	cts With Allocated Funds:				
а	State	the basis of premium rates				
b	Prem	iums paid to carrier			6b	
C	Prem	iums due but unpaid at the end of the year			6c	
d	I If the	carrier, service, or other organization incurred any specific costs i	n connecti	on with		
	the a	cquisition or retention of the contract or policy, enter amount			6d	
		ify nature of costs				
е	Туре	of contract: (1) individual policies (2) group defer	red annuity	/		
	(3)	other (specify)				
f	If cor	tract purchased, in whole or in part, to distribute benefits from a t	erminating	plan, check here	▶	
7	Conti	racts With Unallocated Funds (Do not include portions of these co	ntracts ma	intained in separate acc	counts)	
а	1 Type	of contract: (1) deposit administration (2)	immedi	ate participation guaran	tee	
		(3) guaranteed investment (4)	other	•		
_						
		nce at the end of the previous year			7b	
С		ions: (1) Contributions deposited during the year				
		Dividends and credits				
		nterest credited during the year				
		ransferred from separate account				
	(5) C	Other (specify below)	7c(5)			
	(a) <b>T</b>				7-(6)	0
اء		otal additions			7c(6)	0
		of balance and additions (add lines 7b and 7c(6))			7d	
-	Dedu	ictions: lisbursed from fund to pay benefits or purchase annuities during year	70(1)			
		dministration charge made by carrier				
		ransferred to separate account				
	(4) C	Other (specify below)	7e(4)			
	(5) T	otal deductions			7e(5)	0
f		otal deductions			76(3)	

Da	art III Welfare Benefit Contract Information				
F	If more than one contract covers the same group of employe	oc of the	camo amplovar(s) ar	mombors of	the same
	employee organization(s), the information may be combined				
	as a unit. Where contracts cover individual employees, the en	•	0		•
	treated as a unit for purposes of this report.				•
8	Benefit and contract type (check all applicable boxes)				
	a Health (other than dental or vision)		<b>c</b> Vision		d 🛛 Life insurance
	e Temporary disability (accident and sickness) f Long-term dis	sability	g Supplementa	l unemploym	nent h Prescription drug
	i Stop loss (large deductible) j HMO contrac	•	k PPO contrac		Indemnity contract
	m Other (specify) ▶				
9	Experience-rated contracts:				
а		9a(1)			
		9a(2)			
	, , , , , , , , , , , , , , , , , , , ,	9a(3)			
	(4) Earned ((1) + (2) - (3))			9a(4)	
b		9b(1)			
		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) -	. (4)(4)			
		0c(1)(A)			
	· · · · · · · · · · · · · · · · · · ·	c(1)(B)			
		0c(1)(C)			
	· · · · · · · · · · · · · · · · · · ·	c(1)(D)			
		0c(1)(E)			
		9c(1)(F)			
	•	e(1)(G)		0-4/41	
	(H) Total retention		П	9c(1)(H)	
<b>ل</b> م	(2) Dividends or retroactive rate refunds. (These amounts were Upaid			9c(2)	
u	Status of policyholder reserves at end of year: (1) Amount held to provid			9d(1) 9d(2)	
	(2) Claim reserves			9d(2) 9d(3)	
_	(3) Other reserves			90(3) 9e	
<u>e</u> 10		ea in line s	C(2).)	36	
а				10a	1,215,297
b				100	1,213,23,
	the acquisition or retention of the contract or policy, other than reported				
		•		10b	
Ç,	above, report amount			100	
اد	poonly nature or costs				

Pa	rt IV	Provision of Information			
11	Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
		nswer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration **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

2017

This Form is Open to Public Inspection.

v. 170203

Pension Benefit Guaranty Corporation	▶ File as an attachment to Form 5500.			Public Ir	spection.
For calendar plan year 2017 or fiscal p	lan year beginning $01/01/2017$ and end	ding	12/	31/2017	
A Name of plan DSRA BENEFIT TRUST	PLAN	В	B Three-digit plan number (PN) ▶		
C Plan sponsor's name as shown on DELPHI SALARIED RET	line 2a of Form 5500 IREES ASSOCIATION BENEFIT TRUST	D		/er Identificatio	on Number (EIN)
Part I Service Provider Info	ormation (see instructions)	'			
indirectly, \$5,000 or more in total co the person's position with the plan	cordance with the instructions, to report the information required for ompensation (i.e., money or anything else of monetary value) in conruduring the plan year. If a person received <b>only</b> eligible indirect comped to answer line 1 but are not required to include that person where	nection ensation	with se	rvices rendered hich the plan re	d to the plan or eceived the
1 Information on Persons Re	ceiving Only Eligible Indirect Compensation				
a Check "Yes" or "No" to indicate wh	ether you are excluding a person from the remainder of this Part behich the plan received the required disclosures (see instructions for		-	-	Yes X No
	r the name and EIN or address of each person providing the required compensation. Complete as many entries as needed (see instruction		osures f	or the service p	oroviders
(b) Enter name an	nd EIN or address of person who provided you disclosures on eligibl	e indire	ect com	pensation	
(b) Enter name ar	nd EIN or address of person who provided you disclosures on eligible	e indire	ect com	pensation	
(b) Enter name ar	nd EIN or address of person who provided you disclosures on eligible	e indire	ect com	pensation	
(b) Enter name ar	nd EIN or address of person who provided you disclosures on eligible	e indire	ect com	pensation	
			•		FEOO) 0047
For Paperwork Reduction Act Notice	e, see the Instructions for Form 5500.		5	scneaule C (Fo	orm 5500) 2017

Schedule C (Form 5500) 2017	Page 2 -	
(b) Enter name and EIN or address of person who provided	t you disclosures on eligible indirect compensation	
(b) Enter hame and Ent of address of porson who provides	Type discussion of single mail out semperiodisci	
(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	d 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	d you disclosures on eligible indirect compensation	
(2)	· /	
		_
(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	d you disclosures on eligible indirect compensation	
		_
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation	

					erson receiving, directly or indi	
	ıl compensation (i.e., n an year. (See instructio	, ,	g else of value) in conne	ection with services rend	ered to the plan or their positio	n with the plan during
trie pi	ari year. (See instruction	) is j.	(a) Enter name and FIN	l or address (see instruc	tions)	
MERCE	R		( , =	13-3109248		
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to	Enter direct compensation	Did service provider receive indirect	Did indirect compensation include	Enter total indirect compensation received by	Did the service provider give you
Code(s)	employer, employee organization, or	paid by the	compensation?	eligible indirect	service provider excluding	a formula instead
	person known to be	plan. If none,	(sources other	compensation, for which the plan	eligible indirect compensation for which you	of an amount or
	a party-in-interest	enter -0	than plan or plan sponsor)	received the	answered "Yes" to element	estimated amount?
13	CONTRACT AD	MIN		required disclosures?	(f). If none, enter -0	
13		280,034.	Yes No 🛚	Yes No N		Yes No No
			163 🖺 110 🖽	163    140		163 🖺 110 🖺
			(a) Enter name and EIN	l or address (see instruc	tions)	
FIRST	PERSON CON	SULTING		35-2045879		
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect	Enter total indirect	Did the service
Code(s)	employer, employee organization, or	compensation paid by the	receive indirect compensation?	compensation include eligible indirect	compensation received by service provider excluding	provider give you a formula instead
	person known to be	plan. If none,	(sources other	compensation, for which the plan	eligible indirect compensation for which you	of an amount or
	a party-in-interest	enter -0	than plan or plan sponsor)	received the	answered "Yes" to element	estimated amount?
70	CONSULTING		- pian sponsory	required disclosures?	(f). If none, enter -0	
50		207,845.	Yes No 🛚	Yes No N		Yes No
30		207,043.	res 🔲 No 🕰	res   No		Yes   No
				l or address (see instruc	tions)	
BLUE	CROSS BLUE	SHIELD O	F MICHIGAN	38-2069753		
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect	Enter total indirect	Did the service
Code(s)	employer, employee organization, or	compensation paid by the	receive indirect compensation?	compensation include eligible indirect	compensation received by service provider excluding	provider give you a formula instead
	person known to be	plan. If none,	(sources other	compensation, for	eligible indirect	of an amount or
	a party-in-interest	enter -0	than plan or	which the plan received the	compensation for which you answered "Yes" to element	estimated amount?
4.0			plan sponsor)	required disclosures?	(f). If none, enter -0	
13	CONTRACT AD		ᅠᅠᅠᅟᅠᅜ			🗆 🗆
		159,227.	Yes No X	Yes   No		Yes   No

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom

in tota		noney or anythin	•	· · · · · · · · · · · · · · · · · · ·	erson receiving, directly or indi ered to the plan or their positio	•
tile pi	arr year. (Oce manden	, in 13).	(a) Enter name and EIN	l or address (see instruc	tions)	
COMER	ICA BANK		(-,	38-0477375		
(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?
18 50	CUSTODIAN	16,460.	Yes No 🗓	Yes No		Yes No
KATZ	SAPPER & MI	LLER, LL		or address (see instruc 35-1090346	tions)	
		,				
(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)	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 50	AUDITOR	14,500.	Yes No X	Yes No		Yes No
			(a) Enter name and EIN	l or address (see instruc	tions)	
(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?
			Yes No	Yes No		Yes No

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

# **DFE/Participating Plan 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

2017

This Form is Open to Public Inspection.

For	calendar plan year 2017 or fiscal plan	year beginning 01	/01/2017 and endir	ng 12/31/2017	
A	Name of plan			<b>B</b> Three-digit	
DS	RA BENEFIT TRUST PL	AN		plan number (PN)	501
	Plan or DFE sponsor's name as shown			D Employer Identification I	Number (EIN)
DE	LPHI SALARIED RETIR	EES ASSOCIAT	ION BENEFIT TRUST	26-4594868	
Pa	art I Information on interests	s in MTIAs, CCTs,	PSAs, and 103-12 IEs (to be o	completed by plans an	d DFEs)
	(Complete as many entries as r	•	ests in DFEs)		
а	Name of MTIA, CCT, PSA, or 103-12	IE: COMERICA			
b	Name of sponsor of entity listed in (a	a):AGGRAGATE B	OND INDEX FUND		
		<b>d</b> Entity	e Dollar value of interest in MTIA, CC		
<u>c</u>	EIN-PN 38-6669102 001	code C	or 103-12 IE at end of year (see ins	structions)	219,256.
<u>a</u>	Name of MTIA, CCT, PSA, or 103-12	IE: COMERICA			
<u>b</u>	Name of sponsor of entity listed in (a		E GOVERNMENT BOND I	NDEX FUND	
		<b>d</b> Entity	e Dollar value of interest in MTIA, CC	· · · ·	
<u>c</u>	EIN-PN 38-6727244 001	code C	or 103-12 IE at end of year (see ins	structions)	72,221.
<u>a</u>	Name of MTIA, CCT, PSA, or 103-12	IE: COMERICA			
	Name of sponsor of entity listed in (a): TOTAL US EQUITY INDEX FUND				
b	Name of sponsor of entity listed in (a				
	20 6501005 001	<b>d</b> Entity	e Dollar value of interest in MTIA, CC		-12 025
<u>c</u>	EIN-PN 39-6791907 001	code C	or 103-12 IE at end of year (see ins	structions)	513,937.
<u>a</u>	Name of MTIA, CCT, PSA, or 103-12	! IE:			
L					
b	Name of sponsor of entity listed in (a	<u> </u>	I	T DO.	
_		<b>d</b> Entity	e Dollar value of interest in MTIA, CC or 103-12 IE at end of year (see ins		
<u>c</u>	EIN-PN	code	Or 103-12 IE at end or year (see ins	Structions)	
	Name of MTIA COT DOA on 100 10	IF.			
<u>a</u>	Name of MTIA, CCT, PSA, or 103-12	IE.			
b	Name of apapear of antity listed in (s	n).			
<u>-</u>	Name of sponsor of entity listed in (a	d Entity	e Dollar value of interest in MTIA, CO	T DCA	
С	EIN-PN	code	or 103-12 IE at end of year (see ins		
_	EIIV-FIV	code	or roo 12 12 at ond or your (occ inc	Januario (10)	
	Name of MTIA, CCT, PSA, or 103-12	IE.			
<u>a</u>	Name of WittA, OOT, 1 SA, of 103-12	IL.			
b	Name of sponsor of entity listed in (a	9).			
<u> </u>	Name of sponsor of entity listed in (a	<b>d</b> Entity	e Dollar value of interest in MTIA, CO	T PSA	
С	EIN-PN	code	or 103-12 IE at end of year (see ins	·	
			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
	Name of MTIA, CCT, PSA, or 103-12	! IE:			
b	Name of sponsor of entity listed in (a	a):			
	, , , , , , , , , , , , , , , , , , , ,	<b>d</b> Entity	e Dollar value of interest in MTIA, CO	CT, PSA,	
С	EIN-PN	code	or 103-12 IE at end of year (see ins	· · ·	

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Page	2-
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а	Name of MTIA, CCT, PSA, or 103-12	! IE:	
b	Name of sponsor of entity listed in (a	a):	
	rame or openior or orang motor in (c	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, PSA,
C	EIN-PN	code	or 103-12 IE at end of year (see instructions)
a	Name of MTIA, CCT, PSA, or 103-12	! IE:	
	, ,		
b	Name of sponsor of entity listed in (a		D. D. H. C. L. MTIA COT DOA
С	EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA,     or 103-12 IE at end of year (see instructions)
<u>a</u>	Name of MTIA, CCT, PSA, or 103-12	! IE:	
b	Name of sponsor of entity listed in (a	a):	
	reality increasing to	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, PSA,
<u>c</u>	EIN-PN	code	or 103-12 IE at end of year (see instructions)
	Name of MTIA, CCT, PSA, or 103-12	) IF:	
<u> </u>	Name of WithA, COT, FOA, OF 100 12	. IL.	
<u>b</u>	Name of sponsor of entity listed in (a		
С	EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA,     or 103-12 IE at end of year (see instructions)
	EIN-FIN		or roo 12 12 at one or year (occ monactions)
а	Name of MTIA, CCT, PSA, or 103-12	! IE:	
b	Name of an array of autituality listed in (	۵۰.	
<u> </u>	Name of sponsor of entity listed in (a	d Entity	e Dollar value of interest in MTIA, CCT, PSA,
<u>c</u>	EIN-PN	code	or 103-12 IE at end of year (see instructions)
	N (MTM 00T D0A 10010		
<u>a</u>	Name of MTIA, CCT, PSA, or 103-12	! IE:	
b	Name of sponsor of entity listed in (a		
_	511.1 DA	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, PSA,
С	EIN-PN	code	or 103-12 IE at end of year (see instructions)
а	Name of MTIA, CCT, PSA, or 103-12	! IE:	
L			
<u>b</u>	Name of sponsor of entity listed in (a	a): <b>d</b> Entity	Dollar value of interest in MTIA, CCT, PSA,
С	EIN-PN	code	or 103-12 IE at end of year (see instructions)
<u>a</u>	Name of MTIA, CCT, PSA, or 103-12	! IE:	
b	Name of sponsor of entity listed in (a	a):	
		<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, PSA,
C	EIN-PN	code	or 103-12 IE at end of year (see instructions)
<u></u>	Name of MTIA, CCT, PSA, or 103-12	! IE:	
_			
<u>b</u>	Name of sponsor of entity listed in (a		O Dellawarius of interest in MTIA COT DOA
С	EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA,     or 103-12 IE at end of year (see instructions)
	**		· · · · · · · · · · · · · · · · · · ·

Page 3
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Pa	art II		tion on Participating Plans (to be completed by DFEs) as many entries as needed to report all participating plans)		
			as many entries as needed to report an participating plans)		
<u>a_</u>		n name			
b		ne of		С	EIN-PN
	plan	sponsor			
<u>a</u>		n name			
b		ne of		С	EIN-PN
	plan	sponsor			
<u>a_</u>		n name			
b		ne of		С	EIN-PN
	plan	sponsor			
<u>a_</u>		name		_	
b		ne of		С	EIN-PN
	plan	sponsor			
_					
<u>a</u>		n name			
b		ne of		С	EIN-PN
	plan	sponsor			
_					
<u>a</u>		n name			
b		ne of		С	EIN-PN
	plan	sponsor			
_	- Di				
a b		n name			ENION
D		ne of		С	EIN-PN
	pıan	sponsor			
	Dlan				
a b		n name ne of		C	EIN-PN
D				C	EIN-PIN
	pian	sponsor			
 a	Dlon	n name			
b		ne of		С	EIN-PN
D				C	EIN-FIN
	ріан	sponsor			
 a	Dlon	n name			
b		ne of		С	EIN-PN
		ne oi n sponsor		·	LINTIN
	ріан	i sporisor			
 a	Plan	n name			
b		ne of		С	EIN-PN
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	μαΠ	1 30011301			
	Plan	n name			
<u>b</u>		ne of		С	EIN-PN
-		ne oi n sponsor		•	LIIVI IV
	Piali	1 00011001			

Department of the Treasury Internal Revenue Service

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).

2017

OMB No. 1210-0110

This Form is Open

File as an attachment to Form 5500.

Pension Benefit Guaranty Corporation	5500.		to Pub	olic Inspection			
For calendar plan year 2017 or fiscal	For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017  B Three-digit plan number (PN) ▶ 501						
A Name of plan  DSRA BENEFIT TRUST P							
C Plan sponsor's name as shown on lin	e 2a of Form 5500	D	Employer lo	dentificatio	n Number (EIN)		
DELPHI SALARIED RETIREES ASSOCIATION BENEFIT TRUST 26-4594868							
Part I Asset and Liability St	atement						

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
а	Total noninterest-bearing cash	1a		
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions	1b(1)		
	(2) Participant contributions	1b(2)		
	(3) Other	1b(3)		
С	General investments:			
	(1) Interest-bearing cash (incl. money market accounts & certificates of deposit) $\dots$	1c(1)	58,755	37,820
	(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)	868,518	805,414
	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)	628,204	567,555
(	14) Value of funds held in insurance co. general account (unallocated contracts) $\dots$	1c(14)		
	<b>15)</b> Other	1c(15)		
F 1	Denominant Deducation Act Notice and the Instructions for Form FEOO		Coho	dula H (Earm 5500) 2017

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Schedule H (Form 5500) 2017

v. 170203

l d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	1,555,477	1,410,789
	Liabilities			
g	Benefit claims payable	1g		
h		1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through 1j)	1k		
	Net Assets			
I	Net assets (subtract line 1k from line 1f)	11	1,555,477	1,410,789

#### Part II Income and Expense Statement

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
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
	(B) Participants	2a(1)(B)	21,887,553	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		21,887,553
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market			
	accounts and certificates of deposit)	2b(1)(A)	404	
	(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)		404
	(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)	38,839	
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		38,839
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
	(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)		

				<b>(a)</b> Am	ount	(b	<b>)</b> Total	
	(6) Net investment gain (loss) from common/collective trusts	2b(6)					117	,103
	(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)						,506
С	Other income SEE STATEMENT 1	2c					171	,571
d	Total income. Add all <b>income</b> amounts in column (b) and enter total	2d				22,	,261	,976
	Expenses							
е	Benefit payment and payments to provide benefits:							
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)						
	(2) To insurance carriers for the provision of benefits	2e(2)	2	1,2	17,722			
	(3) Other	2e(3)						
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)				21,	, 217	,722
f	Corrective distributions (see instructions)	2f						
g	Certain deemed distributions of participant loans (see instructions)	2g						
h	Interest expense	2h						
i	Administrative expenses: (1) Professional fees	2i(1)			15,084			
	(2) Contract administrator fees	2i(2)		6	69,831			
	(3) Investment advisory and management fees	2i(3)			16,460			
	(4) Other SEE STATEMENT 2	2i(4)			87,567			
	(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)				1,	188	,942
i	Total expenses. Add all <b>expense</b> amounts in column (b) and enter total	2j				22,	406	,664
•	Net Income and Reconciliation							
k	Net income (loss). Subtract line 2j from line 2d	2k				-	-144	,688
- 1	Transfers of assets:							-
	(1) To this plan	21(1)						
	(2) From this plan	21(2)						
Pa	rt III Accountant's Opinion							
3	Complete lines 3a through 3c if the opinion of an independent qualified public according	ountant is	attache	d to th	is Form 5500	0.		
	Complete line 3d if an opinion is not attached.							
а	The attached opinion of an independent qualified public accountant for this plan is	(see instr	uctions)	:				
		Adverse	-					
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8	and/or 103	-12(d)?			Y	'es	X No
С	Enter the name and EIN of the accountant (or accounting firm) below:							
	(1) Name: SOMERSET CPAS, P.C.			(2) EI	N: 20-1	717681	L	
d								
	(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached	ed to the ne	ext Forn	า 5500	pursuant to	29 CFR 25	520.10	4-50.
Pa	rt IV Compliance Questions							
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not com	plete lines	4a, 4e,	4f, 4g	4h, 4k, 4m,	4n, or 5.		
	103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l							
	During the plan year:			Yes	No	Amo	unt	
а	Was there a failure to transmit to the plan any participant contributions within the t	ime						
	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior ye	ear						
	failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary							
	Correction Program.)		4a		Х			
b	Were any loans by the plan or fixed income obligations due the plan in default as o							
	close of the plan year or classified during the year as uncollectible? Disregard							
	participant loans secured by participant's account balance. (Attach Schedule G (Fo	orm						
	5500) Part I if "Yes" is checked.)		4b		X			

		_		Yes	No		Amount	
С	Were any leases to which the plan was a party in default or classified during the							
	uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		4c		Х			
d	Were there any nonexempt transactions with any party-in-interest? (Do not included)							
	transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes"	' is						
	checked.)		4d		Х			
е	Was this plan covered by a fidelity bond?		4e	X			500,	000
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		Х			
g	Did the plan hold any assets whose current value was neither readily determinal	ble 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 "Y	∕es" is						
	checked, and see instructions for format requirements.)		4i	Х				
j	Were any plan transactions or series of transactions in excess of 5% of the curr							
	value of plan assets? (Attach schedule of transactions if "Yes" is checked, and	see						
	instructions for format requirements.)		4j	Х				
k	Were all the plan assets either distributed to participants or beneficiaries, transfer							
	to another plan, or brought under the control of the PBGC?		4k		Х			
ı	Has the plan failed to provide any benefit when due under the plan?	Г	41		Х			
m	If this is an individual account plan, was there a blackout period? (See instruction	ons						
	and 29 CFR 2520.101-3.)		4m		Х			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the require							
	one of the exceptions to providing the notice applied under 29 CFR 2520.101-3		4n		Х			
5a	Has a resolution to terminate the plan been adopted during the plan year or any	prior plan year?			Yes	X No		
	If "Yes," enter the amount of any plan assets that reverted to the employer this			-	<u> </u>	. –		
5b	If, during this plan year, any assets or liabilities were transferred from this plan to	o another plan(s	), ider	ntify th	ne plan	(s) to which	assets or li	abilities
	were transferred. (See instructions.)							
	5b(1) Name of plan(s)		5b(2)	EIN(s	s)		<b>5b(3)</b> P	N(s)
5 c	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See EF $$	RISA section 4021	.)?	📙	Yes	No	Not dete	rmined
	If "Yes" is checked, enter the My PAA confirmation number from the PBGC prem	nium filing for this	s plar	year			. (See ins	tr.)

SCHEDULE H	OTHER INCOME	STATEMENT 1
DESCRIPTION		AMOUNT
ADMINISTRATIVE FEE INCOME	171,571.	
TOTAL TO SCHEDULE H, LINE	2C	171,571.
SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT 2
DESCRIPTION		AMOUNT
OTHER EXPENSES	487,567.	
TOTAL TO SCHEDULE H, LINE	487,567.	