Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN

HERE

SIGN HERE

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), 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

2009

This Form is Open to Public Inspection

					Inspection	
Part I		tification Information				
For caler	idar plan year 2009 or fiscal p	olan year beginning 01/01/2009		and ending 12/31/2	009	
A This r	eturn/report is for:	a multiemployer plan;	a multiple	-employer plan; or		
		a single-employer plan;	☐ a DFE (sr	pecify)		
		a amgre ampreyer pram,	s (s)			
B This r	eturn/report is:	the first return/report;	the final r	eturn/report;		
		an amended return/report;	a short pl	an year return/report (less th	an 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here	 			
D Check	s box if filing under:	Form 5558;	automatio	extension;	the DFVC program;	
	-	special extension (enter desc	cription)		_	
Part I	I Basic Plan Inform	nation—enter all requested informa	ition			
1a Nam		•			1b Three-digit plan	501
MCM CC	RP EMPLOYEE BENEFIT P	LAN			number (PN) ▶	
					1c Effective date of pla 01/01/2006	ın
20 Diam		· / · · · · · · · · · · · · · · · · · ·	-l\			4:
	sponsor's name and address ess should include room or s	s (employer, if for a single-employer p	olan)		2b Employer Identifica Number (EIN)	tion
MCM CC		and no.)			59-2373403	
mom oc					2c Sponsor's telephone	
					number	
6201 SW	70TH STREET	6304 SW:	70TH STREET		305-541-6869	
2ND FLC	OOR	2ND FLOO			2d Business code (see)
MIAMI, F	L 33143-4718	MIAMI, FL	33143-4718		instructions)	
					236200	
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.						
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.						
	Filed with authorized/valid ele	ctronic signature.	07/08/2010	JENNY RODRIGUEZ-VAR	RGAS	
HERE	Signature of plan administrator		Date	Enter name of individual sign	gning as plan administrator	

07/08/2010

Date

Date

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of DFE

Form 5500 (2009) v.092307.1

GILBERTO RUIZCALDERON

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

	Form 5500 (2009)	Page 2			
	Plan administrator's name and address (if same as plan sponsor, enter "Same"	e")	3		ministrator's EIN 2373403
2N	01 SW 70TH STREET D FLOOR MMI, FL 33143-4718		<u> </u>	nu	ministrator's telephone mber 6-541-6869
4	If the name and/or EIN of the plan sponsor has changed since the last return/re the plan number from the last return/report:	eport filed for this p	olan, enter the name, EIN a	and	4b EIN
а	Sponsor's name				4c PN
5	Total number of participants at the beginning of the plan year			5	303
6	Number of participants as of the end of the plan year (welfare plans complete of	only lines 6a, 6b, 6	c , and 6d).		
а	Active participants			6a	357
b	Retired or separated participants receiving benefits			6b	C
С	Other retired or separated participants entitled to future benefits			6c	C
d	Subtotal. Add lines 6a, 6b, and 6c			6d	357
е	Deceased participants whose beneficiaries are receiving or are entitled to rece	eive benefits		6e	C
f	Total. Add lines 6d and 6e			6f	357
g	Number of participants with account balances as of the end of the plan year (or complete this item)			6g	C
h	Number of participants that terminated employment during the plan year with a less than 100% vested			6h	C
7	Enter the total number of employers obligated to contribute to the plan (only m			7	
	If the plan provides pension benefits, enter the applicable pension feature code of the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits, enter the applicable welfare feature codes for the plan provides welfare benefits.				
	Plan funding arrangement (check all that apply) (1)	(1) X (2) (3) (4)	rrangement (check all that Insurance Code section 412(e)(3) in Trust General assets of the spo	suranc	

b General Schedules

(1)

(2)

(3)

(4)

(5)

(6)

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

(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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					m is Open to Public Inspection		
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009						/31/2009	-
A Name of plan MCM CORP EMPLOYEE BENEFIT PLAN					-digit number (PI	N) •	501
C Plan sponsor's name a MCM CORP	s shown on lin	e 2a of Form 5500.	С	59-2373		ation Number (EIN)
		ning Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
(b) EINI	(c) NAIC	(d) Contract or	(e) Approximate numl persons covered at e			Policy or co	ontract year
(b) EIN	code	identification number	policy or contract ye		(f)	From	(g) To
59-2742907	95263	106354, 106355,	357		01/01/20	09	12/31/2009
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. List	in item 3 t	the agents,	brokers, and c	ther persons in
(a) Total a	amount of com			(b) Tot	al amount	of fees paid	
	40440 19252						
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all per	rsons).			
•		and address of the agent, broker,			ons or fees	were paid	
THE BERENGUER GRO	UP		SW 3RD AVE #220 I, FL 33129				
(b) Amount of sales ar	nd base	Fee	es and other commissions	paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	40440	19252 IN	CENTIVE				3
	(a) Name a	and address of the agent, broker,	or other person to whom o	commissio	ons or fees	were paid	
	,	<u> </u>				·	
(b) Amount of sales ar	nd base	Fee	s and other commissions	paid			
commissions pa		(c) Amount	(d)	(d) Purpose			(e) Organization code
For Paperwork Reduction	n Act Notice a	and OMB Control Numbers, see	the instructions for For	m 5500.		Sch	edule A (Form 5500) 2009

Schedule A (Form 5500)	2009	Page 2- 1	Page 2- 1		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(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, bro	oker, or other person to whom commissions or fees were paid	d		
	I				
(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, bro	oker, or other person to whom commissions or fees were pai			
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-		
(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, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	y be treated	l as a unit for purposes of	
4	Currer	nt value of plan's interest under this contract in the general account at year	end	4	0
		nt value of plan's interest under this contract in separate accounts at year e		. 5	0
_		acts With Allocated Funds:		., -	<u></u>
•		State the basis of premium rates			
	b F	Premiums paid to carrier		. 6b	0
	C F	Premiums due but unpaid at the end of the year		. 6c	0
		f the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	·	6d	0
	5	Specify nature of costs			
	e 7	Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
_		f contract purchased, in whole or in part, to distribute benefits from a termin			
7	Contra	acts With Unallocated Funds (Do not include portions of these contracts ma			
	a 1	 Γype of contract: (1)	ate participation guarantee		
	b E	Balance at the end of the previous year		7b	0
	C A	Additions: (1) Contributions deposited during the year	. 7c(1)	0	
	(2) Dividends and credits	. 7c(2)	0	
	(3) Interest credited during the year	7c(3)	0	
	,	4) Transferred from separate account	7c(4)	0	
	(5) Other (specify below)	. 7c(5)	0	
	•				
	- `	6)Total additions		. 7c(6)	0
		otal of balance and additions (add b and c(6)).		7d	0
		eductions:	7.40		
		1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0	
	•	2) Administration charge made by carrier	. 7e(2)	0	
	•	3) Transferred to separate account	7e(3)	0	
	(4	4) Other (specify below)	. 7e(4)	U	
	•	•			
	(!	5) Total deductions		. 7e(5)	0
	,	Balance at the end of the current year (subtract e(5) from d)		7f	0

Ρ	ag	е	4
г	ay	C	_

Pa	If more than one conformation may be	fit Contract Informat ontract covers the same gree combined for reporting pressure individual contracts of	roup of employees of the urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contracts	oyee organization(s), the cover individual employees,
8	Benefit and contract type (d	check all applicable boxes)					
	a X Health (other than de	ental or vision)	b Dental	С	Vision	C	Life insurance
	e Temporary disability	(accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment ľ	Prescription drug
	i Stop loss (large ded	uctible)	i HMO contract	k	PPO contract		Indemnity contract
	m ☐ Other (specify) ▶			_			
9	Experience-rated contracts	:					
	a Premiums: (1) Amount	received		. 9a(1)		0	
	(2) Increase (decrease	e) in amount due but unpaid	db			0	
	` '	e) in unearned premium res				0	
		(3))				9a(4)	0
	• ,	aims paid		:-:		0	
	` '	e) in claim reserves				T	0
	` ,	ld (1) and (2))				9b(3) 9b(4)	0
	` '	m: (1) Retention charges (c				90(4)	U
		t) Retention charges (c		9c(1)(A)		0	
	` '	service or other fees				0	
		acquisition costs		0 (4)(0)		0	
	` ,	98		- (1)(-)		0	
				0 (4)(E)		0	
	` '	sks or other contingencies.		0 (4)(5)		0	
	(G) Other retention	n charges		9c(1)(G)		0	
	(H) Total retention	·				9c(1)(H)	0
	(2) Dividends or retroa	active rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)	0
	d Status of policyholder	reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	0
	(2) Claim reserves					9d(2)	0
	(3) Other reserves					9d(3)	0
	e Dividends or retroactive	ve rate refunds due. (Do n	ot include amount entered	d in c(2) .)		9e	0
10	Nonexperience-rated con	tracts:					
	a Total premiums or sub	oscription charges paid to o	carrier			10a	890429
		or other organization incur act or policy, other than rep	, ,			10b	0
	Specify nature of costs						

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			1111	This Form is Open to Public Inspection				
For calendar plan year 20	09 or fiscal pla	n year beginning 01/01/2009	and e	nding 12/31/2009				
A Name of plan MCM CORP EMPLOYEE	BENEFIT PLA	AN		ee-digit n number (PN)	501			
C Plan sponsor's name a MCM CORP	nber (EIN)							
on a separa	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 Information:								
(a) Name of insurance ca		OMPANY						
/I.A. EIAI	(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) To			
13-5581829	65978	TMO5732565	226	01/01/2009	12/31/2009			
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item 3	3 the agents, brokers,	and other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid								
4630 17								
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all persons)					
• Torono receiving con		and address of the agent, broker, o		sions or fees were paid				
J.M. BERENGUER & AS		2929 S	SW 3RD AVE, STE 220 , FL 33129-2751	,	-			
(b) Amount of sales a	nd hase	Fees	s and other commissions paid					
commissions pa		(c) Amount	(d) Purpos	(e) Organization code				
	4630	17 NO	N-MONETARY COMPENSATION	N	3			
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	sions or fees were paid				
	(a) · ··a····	and again, broker, t		or 1000 11010 par	-			
(b) Amount of sales a	nd hase	Fees	s and other commissions paid					
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code			
				· · · · · · · · · · · · · · · · · · ·				

Schedule A (Form 5500)	2009	Page 2- 1	Page 2- 1		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(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, bro	oker, or other person to whom commissions or fees were paid	d		
	I				
(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, bro	oker, or other person to whom commissions or fees were pai			
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-		
(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, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	y be treated	l as a unit for purposes of	
4	Currer	nt value of plan's interest under this contract in the general account at year	end	4	0
		nt value of plan's interest under this contract in separate accounts at year e		. 5	0
_		acts With Allocated Funds:		<u>., </u>	<u></u>
•		State the basis of premium rates			
	b F	Premiums paid to carrier		. 6b	0
	C F	Premiums due but unpaid at the end of the year		. 6с	0
		f the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	·	6d	0
	5	Specify nature of costs			
	e 7	Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
_		f contract purchased, in whole or in part, to distribute benefits from a termin			
7	Contra	acts With Unallocated Funds (Do not include portions of these contracts ma			
	a 1	 Γype of contract: (1)	ate participation guarantee		
	b E	Balance at the end of the previous year		7b	0
	C A	Additions: (1) Contributions deposited during the year	. 7c(1)	0	
	(2) Dividends and credits	. 7c(2)	0	
	(3) Interest credited during the year	7c(3)	0	
	,	4) Transferred from separate account	7c(4)	0	
	(5) Other (specify below)	. 7c(5)	0	
	•				
	- `	6)Total additions		. 7c(6)	0
		otal of balance and additions (add b and c(6)).		7d	0
		eductions:	7.40		
		1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0	
	•	2) Administration charge made by carrier	. 7e(2)	0	
	•	3) Transferred to separate account	7e(3)	0	
	(4	4) Other (specify below)	. 7e(4)	U	
	•	•			
	(!	5) Total deductions		. 7e(5)	0
	,	Balance at the end of the current year (subtract e(5) from d)		7f	0

Ρ	ag	е	4
г	ay	C	_

X No

Yes

Part								
	III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts of	oup	es if such contracts	are experience	ce-rated as a unit. W	here contrac	
8 Be	ene	fit and contract type (check all applicable boxes)		· · · · · · · · · · · · · · · · · · ·			-	
a	_	Health (other than dental or vision)	_	Dental	сГ	Vision		d Life insurance
	H				<u> </u>	=		
e	Ļ	Temporary disability (accident and sickness)	Ţ	Long-term disabili		=	nployment	h Prescription drug
İ	L	Stop loss (large deductible)	j	HMO contract	k	PPO contract		I Indemnity contract
m	<u> </u>	Other (specify)						
9 Ex	ре	rience-rated contracts:						
а	Ρ	remiums: (1) Amount received			. 9a(1)		(
	((2) Increase (decrease) in amount due but unpaid	b		. 9a(2)		(
	((3) Increase (decrease) in unearned premium res	erve		. 9a(3)		(
	((4) Earned ((1) + (2) - (3))						0
b		Benefit charges (1) Claims paid					C	
		(2) Increase (decrease) in claim reserves					(
	((3) Incurred claims (add (1) and (2))					9b(3)	0
	,	(4) Claims charged					9b(4)	0
C	;	Remainder of premium: (1) Retention charges (o	n an	accrual basis)				_
		(A) Commissions			9c(1)(A)		(_
		(B) Administrative service or other fees			2 (4)(2)		(_
		(C) Other specific acquisition costs					(
		(D) Other expenses					(
		(E) Taxes					(
		(F) Charges for risks or other contingencies.					(
		(G) Other retention charges						0
		(H) Total retention		_				
		(2) Dividends or retroactive rate refunds. (These						0
C		Status of policyholder reserves at end of year: (1	,	•				0
		(2) Claim reserves						0
		(3) Other reserves					· · · · ·	0
40		Dividends or retroactive rate refunds due. (Do n	ot inc	clude amount entere	d in c(2) .)		9e	0
10 1		nexperience-rated contracts:						40004
9		Total premiums or subscription charges paid to c					<u>10a</u>	46304
	`	If the carrier, service, or other organization incur					10b	0
b		retention of the contract or policy, other than rep	orted	iii i ait i, itoiii z abo	,			

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

Provision of Information

Part IV

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.

OMB No. 1210-0110

T ension benefit duaranty of	эгрогацоп	Insurance companies ar pursuant to EF	This Fo	This Form is Open to Public Inspection			
For calendar plan year 20	09 or fiscal plar	year beginning 01/01/2009	and e	ending 12/31/2009			
A Name of plan MCM CORP EMPLOYEE	BENEFIT PLA	N		ee-digit n number (PN)	501		
C Plan sponsor's name as shown on line 2a of Form 5500. MCM CORP D Employer Identification Number (EIN) 59-2373403							
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca							
SAFEGUARD HEALTH F	PLANS INC						
	(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) To		
95-2879515	96030	5732565	219	01/01/2009	12/31/2009		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in item 3	3 the agents, brokers, and	other persons in		
(a) Total	amount of comr		(b) T	otal amount of fees paid			
		2445			0		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	is needed to report all persons).				
		nd address of the agent, broker, c		sions or fees were paid			
JM BERENGUER & ASS		2929 S	W 3RD AVE STE 220 , FL 33129-2751	,			
(b) Amount of sales a			and other commissions paid	(-) (
commissions pa	2445	(c) Amount	(d) Purpos	(e) Organization code			
	2443	o d			3		
	(a) Name a	nd address of the agent, broker, c	or other person to whom commiss	sions or fees were paid			
(b) Amount of sales a	nd hase	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code		

Schedule A (Form 5500)	2009	Page 2- 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(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, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(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, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(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, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each carrier ma	y be treated	l as a unit for purposes of
4	Currer	nt value of plan's interest under this contract in the general account at year	end	4	0
		nt value of plan's interest under this contract in separate accounts at year e		. 5	0
_		acts With Allocated Funds:		<u>., </u>	<u></u>
•		State the basis of premium rates			
	b F	Premiums paid to carrier		. 6b	0
	C F	Premiums due but unpaid at the end of the year		. 6с	0
		f the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	·	6d	0
	5	Specify nature of costs			
	e 7	Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
_		f contract purchased, in whole or in part, to distribute benefits from a termin			
7	Contra	acts With Unallocated Funds (Do not include portions of these contracts ma			
	a 1	 Γype of contract: (1)	ate participation guarantee		
	b E	Balance at the end of the previous year		7b	0
	C A	Additions: (1) Contributions deposited during the year	. 7c(1)	0	
	(2) Dividends and credits	. 7c(2)	0	
	(3) Interest credited during the year	7c(3)	0	
	,	4) Transferred from separate account	7c(4)	0	
	(5) Other (specify below)	. 7c(5)	0	
	•				
	- `	6)Total additions		. 7c(6)	0
		otal of balance and additions (add b and c(6)).		7d	0
		eductions:	7.40		
		1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0	
	•	2) Administration charge made by carrier	. 7e(2)	0	
	•	3) Transferred to separate account	7e(3)	0	
	(4	4) Other (specify below)	. 7e(4)	U	
	•	•			
	(!	5) Total deductions		. 7e(5)	0
	,	Balance at the end of the current year (subtract e(5) from d)		7f	0

Pag	е	4

Pa	art II	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 em	such contracts a	re experien	ce-rated as a unit. Wi	nere contracts	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X De	ntal	С	Vision	(Life insurance
	е	Temporary disability (accident and sickness)	f Lo	ng-term disability	, g	Supplemental unem	ployment I	n Prescription drug
	i	Stop loss (large deductible)	j 📈 HM	10 contract	k [PPO contract		I Indemnity contract
	m	Other (specify)	- <u>Б</u>		_	-		
9	Ехре	erience-rated contracts:						
	а	Premiums: (1) Amount received			9a(1)		0	
		(2) Increase (decrease) in amount due but unpaid	l		9a(2)		0	
		(3) Increase (decrease) in unearned premium res	erve		9a(3)		0	
		(4) Earned ((1) + (2) - (3))		<u>.</u>			9a(4)	0
	b	Benefit charges (1) Claims paid			9b(1)		0	
		(2) Increase (decrease) in claim reserves			9b(2)		0	
		(3) Incurred claims (add (1) and (2))					9b(3)	0
		(4) Claims charged					9b(4)	0
	С	Remainder of premium: (1) Retention charges (o	n an accru	ual basis)				
		(A) Commissions			9c(1)(A)		0	
		(B) Administrative service or other fees			9c(1)(B)		0	
		(C) Other specific acquisition costs			9c(1)(C)		0	
		(D) Other expenses			9c(1)(D)		0	
		(E) Taxes			9c(1)(E)		0	
		(F) Charges for risks or other contingencies			9c(1)(F)		0	
		(G) Other retention charges			9c(1)(G)		0	
		(H) Total retention					9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These	amounts	were paid in	cash, or	credited.)	9c(2)	0
	d	Status of policyholder reserves at end of year: (1) Amount	held to provide b	enefits after	retirement		0
		(2) Claim reserves		······			9d(2)	0
		(3) Other reserves					9d(3)	0
	е	Dividends or retroactive rate refunds due. (Do no						0
10	No	nexperience-rated contracts:			• • • • • • • • • • • • • • • • • • • •		1	
	а	Total premiums or subscription charges paid to c	arrier				10a	16303
	b	If the carrier, service, or other organization incurr					. 10b	0
	٥.	retention of the contract or policy, other than repo pecify nature of costs	nted in Pa	art i, itemi z abov	e, report am	ount	. 100	
	3,	recity flature or costs. P						

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

Pension Benefit Guaranty Co	orporation		Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection	
For calendar plan year 20	09 or fiscal pla	n year beginning 01/01/2009	ar	d ending 12	2/31/2009	-	
A Name of plan MCM CORP EMPLOYEE	501						
C Plan sponsor's name a MCM CORP	as shown on lir	ne 2a of Form 5500.		nployer Identific -2373403	cation Number (EIN)	
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		NCE COMPANY					
	(a) NIAIC	(d) Contract or	(e) Approximate number of	of	Policy or co	ontract year	
(b) EIN	(c) NAIC code	identification number	persons covered at end o policy or contract year	f (f)	From	(g) To	
36-0883760	68381	VG 181459	72	01/01/20	009	12/31/2009	
2 Insurance fee and com descending order of the		nation. Enter the total fees and tota	I commissions paid. List in ite	em 3 the agents	s, brokers, and o	other persons in	
(a) Total	amount of com	nmissions paid	(k) Total amount	of fees paid		
		2353				0	
3 Persons receiving com	missions and	fees. (Complete as many entries a	as needed to report all person	s).			
		and address of the agent, broker,			s were paid		
J.M. BERENGUER & AS		IC. 2929 S	S.W. 3RD AVENUE, STE 220 , FL 33129				
(b) Amount of sales ar	nd hase	Fees	s and other commissions paid				
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	2353	0				3	
	(a) Name	and address of the agent, broker,	or other person to whom comi	missions or fees	s were paid		
(b) Amount of sales ar	nd base	Fee	s and other commissions paid				
commissions pa		(c) Amount	(d) Pur	pose		(e) Organization code	
For Paperwork Reduction	n Act Notice	and OMB Control Numbers, see	the instructions for Form 5	500.	Sch	edule A (Form 5500) 2009	

Schedule A (Form 5500)	2009	Page 2- 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(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, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(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, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(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, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each carrier ma	y be treated	l as a unit for purposes of
4	Currer	nt value of plan's interest under this contract in the general account at year	end	4	0
		nt value of plan's interest under this contract in separate accounts at year e		. 5	0
_		acts With Allocated Funds:		<u>., </u>	<u></u>
•		State the basis of premium rates			
	b F	Premiums paid to carrier		. 6b	0
	C F	Premiums due but unpaid at the end of the year		. 6c	0
		f the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	·	6d	0
	5	Specify nature of costs			
	e 7	Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
_		f contract purchased, in whole or in part, to distribute benefits from a termin			
7	Contra	acts With Unallocated Funds (Do not include portions of these contracts ma			
	a 1	 Γype of contract: (1)	ate participation guarantee		
	b E	Balance at the end of the previous year		7b	0
	C A	Additions: (1) Contributions deposited during the year	. 7c(1)	0	
	(2) Dividends and credits	. 7c(2)	0	
	(3) Interest credited during the year	7c(3)	0	
	,	4) Transferred from separate account	7c(4)	0	
	(5) Other (specify below)	. 7c(5)	0	
	•				
	- `	6)Total additions		. 7c(6)	0
		otal of balance and additions (add b and c(6)).		7d	0
		eductions:	7.40		
		1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0	
	•	2) Administration charge made by carrier	. 7e(2)	0	
	•	3) Transferred to separate account	7e(3)	0	
	(4	4) Other (specify below)	. 7e(4)	U	
	•	•			
	(!	5) Total deductions		. 7e(5)	0
	,	Balance at the end of the current year (subtract e(5) from d)		7f	0

Pag	е	4

Pa	information may be combined f	ct Information rs the same group of employees for reporting purposes if such co lual contracts with each carrier n	entracts are experience-rated	as a unit. Where contracts	
8	Benefit and contract type (check all app	licable boxes)			
	a Health (other than dental or visio	n) b Dental	c Vision	n (Life insurance
	e Temporary disability (accident ar	nd sickness) f Long-term	disability g Suppl	emental unemployment	Prescription drug
	i Stop loss (large deductible)	j HMO conti	ract k PPO	contract	I Indemnity contract
	m ☐ Other (specify) ▶	,			- I made many definition
9	Experience-rated contracts:				
	a Premiums: (1) Amount received			0	
	(2) Increase (decrease) in amount	due but unpaid		0	
	(3) Increase (decrease) in unearne	•		0	_
	(4) Earned ((1) + (2) - (3))				0
	b Benefit charges (1) Claims paid			0	_
	(2) Increase (decrease) in claim res			0	
	(3) Incurred claims (add (1) and (2)				0
	(4) Claims charged			9b(4)	0
	C Remainder of premium: (1) Retent	• ,	<i>'</i>	0	
	` '			0	
	· /	ther fees	0 (4)(0)	0	
		osts	0 (4)(5)	0	
				0	
				0	
	(F) Charges for risks or other o	contingencies		0	
					0
	` '	f	. —		0
	(2) Dividends or retroactive rate re	· —			0
	d Status of policyholder reserves at o	, ()	•		0
	(2) Claim reserves				0
	(3) Other reserves				0
10	Dividends or retroactive rate refund	as due. (Do not include amount	entered in c(2) .)	9e	U
10	Nonexperience-rated contracts: Tatal promises or subscription about	arman paid to corrier		100	23365
	a Total premiums or subscription cha	• .			23303
	b If the carrier, service, or other organ retention of the contract or policy, or			·	0
	Specify nature of costs				

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

Pension Benefit Guaranty Co		Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection		
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009							
A Name of plan MCM CORP EMPLOYEE BENEFIT PLAN				hree-digit Ian number (PI	N) •	501	
C Plan sponsor's name a MCM CORP	is shown on line	e 2a of Form 5500.		nployer Identific 2373403	cation Number	(EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		COMPANY					
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		Policy or c	ontract year	
(b) EIN	code	identification number	policy or contract year	(f)	From	(g) To	
47-0322111	69868	GLTD0ABLG	27 11/01/2008		800	10/31/2009	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in iter	m 3 the agents	, brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid			of fees paid				
2007					0		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons	i).			
	(a) Name a	nd address of the agent, broker, o		issions or fees	were paid		
CUNDY INC 333 EAST LAS OLAS BLVD FORT LAUDERDALE, FL 33301-2262							
(b) Amount of sales ar	nd hase	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purp	(d) Purpose		(e) Organization code	
2007		0				3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales and base commissions paid		Fees and other commiss		sions paid			
		(c) Amount		(d) Purpose		(e) Organization code	
For Denovycetic Reduction Act Nation and OMP Central Numbers are the instructions for Form 5500				odulo A (Form 5500) 2000			

Schedule A (Form 5500)	2009	Page 2- 1					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(a) Hame and dadress of the agent, stoner, or each person to whom sommosters or lose were paid							
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(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, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker or other person to whom commissions or fees were pair					
(a) Name and address of the agent, broker, 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 and address of the agent, broker, 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				

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each carrier ma	y be treated	l as a unit for purposes of		
4	Currer	nt value of plan's interest under this contract in the general account at year	end	4	0		
		nt value of plan's interest under this contract in separate accounts at year e		. 5	0		
_		acts With Allocated Funds:		<u>., </u>	<u></u>		
•							
	b F	Premiums paid to carrier		. 6b	0		
	C F	Premiums due but unpaid at the end of the year		. 6c	0		
		f the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	·	6d	0		
	5	Specify nature of costs					
	e 7	Type of contract: (1) individual policies (2) group deferred	d annuity				
	(3) other (specify)					
_		f contract purchased, in whole or in part, to distribute benefits from a termin					
7	Contra	acts With Unallocated Funds (Do not include portions of these contracts ma					
	a 1	 Γype of contract: (1)	ate participation guarantee				
	b E	Balance at the end of the previous year		7b	0		
	C A	Additions: (1) Contributions deposited during the year	. 7c(1)	0			
	(2) Dividends and credits	. 7c(2)	0			
	(3) Interest credited during the year	7c(3)	0			
	,	4) Transferred from separate account	7c(4)	0			
	(5) Other (specify below)	. 7c(5)	0			
	•						
	- `	6)Total additions		. 7c(6)	0		
		otal of balance and additions (add b and c(6)).		7d	0		
		eductions:	7.40				
		1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0			
	•	2) Administration charge made by carrier	. 7e(2)	0			
	•	3) Transferred to separate account	7e(3)	0			
	(4	4) Other (specify below)	. 7e(4)	U			
	•	•					
	(!	5) Total deductions		. 7e(5)	0		
	,	Balance at the end of the current year (subtract e(5) from d)		7f	0		

Ρ	ag	е	4
г	ay	E	7

	If more than one contract covers the same ground information may be combined for reporting puthe entire group of such individual contracts we	oup of employees of the rposes if such contracts	are experience	e-rated as a unit. Wh	ere contracts	
8	Benefit and contract type (check all applicable boxes)					
	a Health (other than dental or vision)	b Dental	С	Vision	(Life insurance
	e Temporary disability (accident and sickness)	f X Long-term disabili	ity g	Supplemental unem	oloyment I	n Prescription drug
	i Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶	_		•		_ ,
9	Experience-rated contracts:					
	a Premiums: (1) Amount received				0	
	(2) Increase (decrease) in amount due but unpaid		. 9a(2)		0	
	(3) Increase (decrease) in unearned premium rese	erve	. 9a(3)		0	
	(4) Earned ((1) + (2) - (3))				9a(4)	0
	b Benefit charges (1) Claims paid				0	
	(2) Increase (decrease) in claim reserves		. 9b(2)		0	
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged				9b(4)	0
	c Remainder of premium: (1) Retention charges (or	,				
	(A) Commissions		9c(1)(A)		0	
	(B) Administrative service or other fees		2 (4)(2)		0	
	(C) Other specific acquisition costs		2 (1)(2)		0	
	(D) Other expenses		0 (4)(=)		0	
	(E) Taxes		2 (1) (2)		0	
	(F) Charges for risks or other contingencies				0	
	(G) Other retention charges					0
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	ш .	· Ш	,	9c(2)	0
	d Status of policyholder reserves at end of year: (1)	•			9d(1)	0
	(2) Claim reserves				9d(2)	0
	(3) Other reserves				9d(3)	0
40	e Dividends or retroactive rate refunds due. (Do no	t include amount entere	d in c(2) .)		. 9e	U
10	Nonexperience-rated contracts:				40-	16470
	a Total premiums or subscription charges paid to ca				10a	10470
	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			0		
	Specify nature of costs					

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