

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 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

Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning <u>10/01/2008</u> and ending <u>09/30/2009</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>
D Check box if filing under:	<input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information
1a Name of plan <u>LONG TERM DISABILITY PLAN FOR ELIGIBLE UCAR STAFF</u>	1b Three-digit plan number (PN) ▶ <u>513</u> 1c Effective date of plan
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>UNIVERSITY CORPORATION FOR ATMOSPHERIC RESEARCH</u> <u>1850 TABLE MESA DRIVE</u> <u>PO BOX 3000</u> <u>BOULDER, CO 80307</u>	2b Employer Identification Number (EIN) <u>84-0412668</u> 2c Sponsor's telephone number 2d Business code (see instructions)

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.

SIGN HERE			
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2009)
v.092307.1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") UNIVERSITY CORPORATION FOR ATMOSPHERIC RESEARCH 1850 TABLE MESA DRIVE PO BOX 3000 BOULDER, CO 80307	3b Administrator's EIN 84-0412668 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).	
a Active participants.....	6a
b Retired or separated participants receiving benefits.....	6b
c Other retired or separated participants entitled to future benefits.....	6c
d Subtotal. Add lines 6a , 6b , and 6c	6d
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e
f Total. Add lines 6d and 6e	6f
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:	

9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

Form **5500**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit PlanThis form is required to be filed under sections 104 and 4065 of the Employee
Retirement Income Security Act of 1974 (ERISA) and sections 6047(e),
6057(b), and 6058(a) of the Internal Revenue Code (the Code).▶ Complete all entries in accordance with
the instructions to the Form 5500.Official Use Only
OMB Nos. 1210-0110
1210-0089**2008****This Form is Open to
Public Inspection.****Part I Annual Report Identification Information**

For the calendar plan year 2008 or fiscal plan year beginning 10/01/2008, and ending 09/30/2009,

- A** This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan; or
(2) ☒ a single-employer plan (other than a (4) ☐ a DFE (specify) _____
multiple-employer plan);
- B** This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☐
- D** If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ☒

Part II Basic Plan Information — enter all requested information.

1a Name of plan LONG TERM DISABILITY PLAN FOR ELIGIBLE UCAR STAFF	1b Three-digit plan number (PN) ▶ 513
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) UNIVERSITY CORPORATION FOR ATMOSPHERIC RESEARCH 1850 TABLE MESA DRIVE P.O. BOX 3000 BOULDER CO 80307	1c Effective date of plan (mo., day, yr.) 07/01/1962 2b Employer Identification Number (EIN) 84-0412668 2c Sponsor's telephone number 303-497-1000 2d Business code (see instructions) 611000

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 if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

SIGN HERE	<i>Laurie Carr</i>	7/8/10	LAURIE CARR
	Signature of plan administrator	Date	Type or print name of individual signing as plan administrator
SIGN HERE	<i>Laurie Carr</i>	7/8/10	LAURIE CARR
	Signature of employer/plan sponsor/DFE	Date	Type or print name of individual signing as employer, plan sponsor or DFE

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

v11.3

Form **5500** (2008)
RECEIVED
 JUL 15 2010
 BY: _____


3a Plan administrator's name and address (If same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address
TOWERS WATSON
950 17TH STREET, STE. 1400

b EIN

53-0181291

c Telephone number

303-298-7878

DENVER

CO

80202

6 Total number of participants at the beginning of the plan year	6	1271
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	1292
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	0
d Subtotal. Add lines 7a, 7b, and 7c	7d	1292
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	
f Total. Add lines 7d and 7e	7f	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

- a** ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
- b** ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions): 4H ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

9a Plan funding arrangement (check all that apply)

- (1) ☒ Insurance
(2) ☐ Code section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
(2) ☐ Code section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

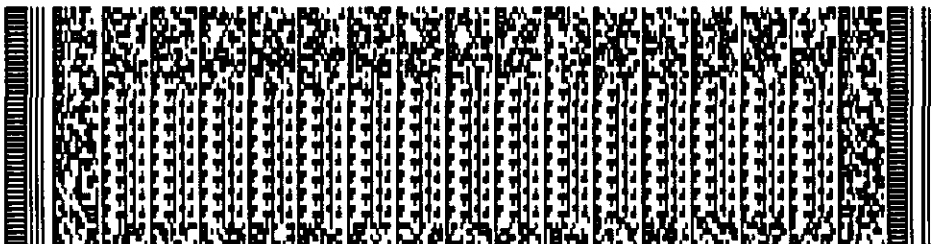


10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)**a Pension Benefit Schedules**

- | | | | |
|-----|--------------------------|------------|--|
| (1) | <input type="checkbox"/> | R | (Retirement Plan Information) |
| (2) | <input type="checkbox"/> | B | (Actuarial Information) |
| (3) | <input type="checkbox"/> | E | (ESOP Annual Information) |
| (4) | <input type="checkbox"/> | SSA | (Separated Vested Participant Information) |

b Financial Schedules

- | | | | |
|-----|---------------------------------------|----------|---------------------------------------|
| (1) | <input type="checkbox"/> | H | (Financial Information) |
| (2) | <input type="checkbox"/> | I | (Financial Information -- Small Plan) |
| (3) | <input checked="" type="checkbox"/> 1 | A | (Insurance Information) |
| (4) | <input type="checkbox"/> | C | (Service Provider Information) |
| (5) | <input type="checkbox"/> | D | (DFE/Participating Plan Information) |
| (6) | <input type="checkbox"/> | G | (Financial Transaction Schedules) |



**SCHEDULE A
(Form 5500)**

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.

► **File as an attachment to Form 5500.**

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

Official Use Only

OMB No. 1210-0110

2008

**This Form is Open to
Public Inspection.**

For calendar plan year 2008 or fiscal plan year beginning 10/01/2008 and ending 09/30/2009

A Name of plan LONG TERM DISABILITY PLAN FOR ELIGIBLE UCAR STAFF	B Three-digit plan number ► 513
C Plan sponsor's name as shown on line 2a of Form 5500 UNIVERSITY CORPORATION FOR ATMOSPHERIC RESEARCH	D Employer Identification Number 84-0412668

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:

(a) Name of insurance carrier

STANDARD INSURANCE COMPANY

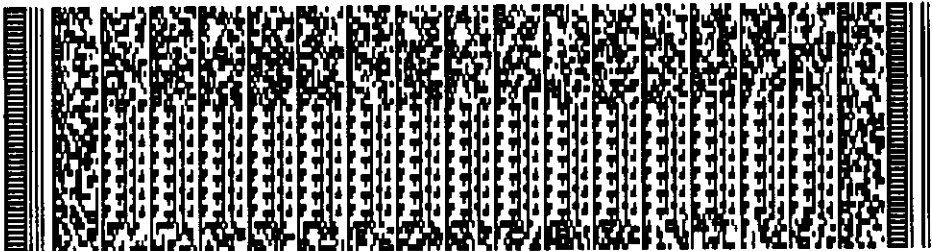
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0242990	69019	135037	1244	01/01/2008	12/31/2008

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid	Total fees paid / amount
0	0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v11.3 Schedule A (Form 5500) 2008



(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

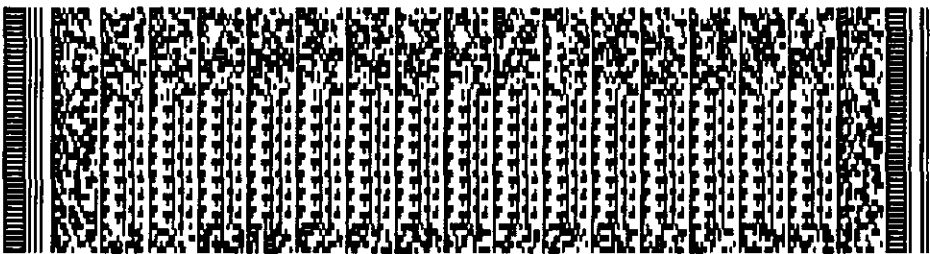
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end	
5	Contracts With Allocated Funds	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	
c	Premiums due but unpaid at the end of the year	
d	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.	
	Specify nature of costs ▶	
e	Type of contract (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other (specify below) ▶	
b	Balance at the end of the previous year	
c	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)	
	(6) Total additions	
d	Total of balance and additions (add b and c(6))	
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	
	(2) Administration charge made by carrier	
	(3) Transferred to separate account	
	(4) Other (specify below)	
	(5) Total deductions	
f	Balance at the end of the current year (subtract e(5) from d)	



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)

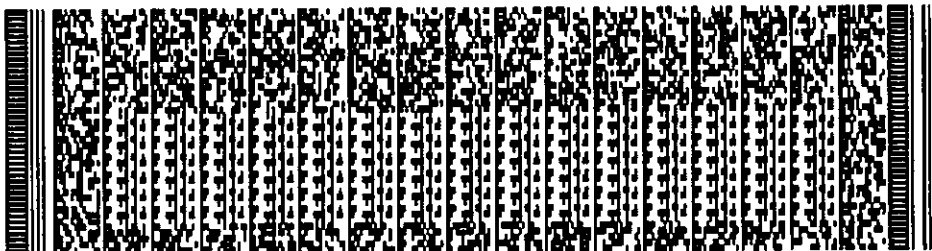
- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life Insurance
e ☐ Temporary disability (accident and sickness) **f** ☒ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☐ Other (specify) ▶

8 Experience-rated contracts

a Premiums: (1) Amount received	779893	
(2) Increase (decrease) in amount due but unpaid	0	
(3) Increase (decrease) in unearned premium reserve	0	
(4) Earned ((1) + (2) - (3))		779893
b Benefit charges: (1) Claims paid	397399	
(2) Increase (decrease) in claim reserves	-112954	
(3) Incurred claims (add (1) and (2))		284445
(4) Claims charged		
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	0	
(B) Administrative service or other fees	0	
(C) Other specific acquisition costs	0	
(D) Other expenses	68860	
(E) Taxes	15597	
(F) Charges for risks or other contingencies	93587	
(G) Other retention charges	317404	
(H) Total retention		495448
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		0
(2) Claim reserves		1725004
(3) Other reserves		0
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		0

9 Nonexperience-rated contracts:

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



► For Privacy Act and Paperwork Reduction Act Notice, see instructions on page 3.

Part I Identification

A	Name of filer, plan administrator, or plan sponsor (see instructions) University Corporation for Atmospheric Research	B Filer's identifying number (see instructions). <input checked="checked" type="checkbox"/> Employer identification number (EIN). 84-0412668					
	Number, street, and room or suite no. (If a P.O. box, see instructions) 1850 Table Mesa Drive P.O. Box 3000	<input type="checkbox"/> Social security number (SSN)					
	City or town, state, and ZIP code Boulder CO 80307						
C	Plan name	Plan number			Plan year ending—		
					MM	DD	YYYY
	1 Long Term Disability Plan for Eligible UCAR Staff	5	1	3	9	30	2009
	2						
3							

Part II Extension of Time to File Form 5500 or Form 5500-EZ (see instructions)

1 I request an extension of time until 7 / 15 / 2010 to file Form 5500 or Form 5500-EZ.

The application is **automatically approved** to the date shown on line 1 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and **(b)** the date on line 1 is no more than 2½ months after the normal due date.

You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed in C above.

Note. A signature is not required if you are requesting an extension to file Form 5500 or Form 5500-EZ.

Part III Extension of Time to File Form 5330 (see instructions)

2 I request an extension of time until / / to file Form 5330.

You may be approved for up to a six (6) month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax **a** _____

b Enter the payment amount attached	b	
--	----------	--

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . c _____

3 State in detail why you need the extension

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ►

Date ►

ress

RT 469 6

4158
07:09

FedEx Ship Manager - Print Your Label(s)

<https://www.fedex.com/shipping/confirmAction.handle?method=doCo...>

From: Origin ID: FNLA (303) 497-8710
Cyd Perrone
UCAR
1850 Table Mesa Dr.
Boulder, CO 80305



Ship Date: 08 JUL 10
ActWgt: 1.0 LB
CAD: 5262528/INET3060

Delivery Address Bar Code



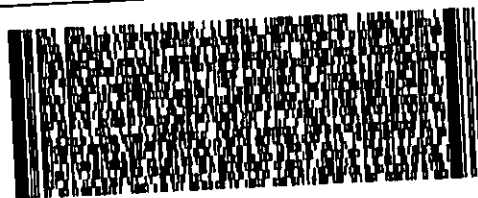
Ref # 313620
Invoice #
PO #
Dept #

SHIP TO: (303) 497-8710

BILL SENDER

Attn: EFAST
EBSA
3833 GREENWAY DR

LAWRENCE, KS 66046



TRK# 7937 0751 4158
0201

FRI - 09 JUL A2
STANDARD OVERNIGHT

66046

KS-US

MCI

XH IXDA



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