### 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	10110	
Part I	Annual Report Identif	ication Information					
For caler	ndar plan year 2009 or fiscal plar	year beginning 01/01/2009		and ending 12/31/	2009		
A This	eturn/report is for:	a multiemployer plan;	a multipl	e-employer plan; or			
	$\overline{X}$ a single-employer plan;			specify)			
<b>B</b> This r	eturn/report is:	the first return/report;	the final	return/report;			
		an amended return/report;	a short p	olan year return/report (less t	than 12 months).		
<b>C</b> If the	plan is a collectively-bargained p	olan, check here					
D Chec	k box if filing under:	X Form 5558;		c extension;	the DFVC program;		
2 01100	K DOX II IIIII g artaor.	special extension (enter des		,			
Part	I Racio Plan Informat	tion—enter all requested information					
	e of plan	iivii—enter an requesteu miorma	ation		<b>1b</b> Three-digit plan		
	REET CAPITAL MANAGEMEN	T WELFARE BENEFITS PLAN			number (PN) ▶	501	
					1c Effective date of pla	an	
					01/01/1998		
	•	employer, if for a single-employer p	plan)		<b>2b</b> Employer Identification Number (EIN)		
(Address should include room or suite no.) KING STREET CAPITAL MANAGEMENT, LP					13-3978904		
TUITO O	TEET ON TIME WIND TO COME	,			2c Sponsor's telephon	ne	
					number		
65 EAST	55TH STREET, 30TH FLOOR	65 FAST !	55TH STREET, 30T	H FLOOR	212-812-3112		
	PRK, NY 10022	NEW YOR	RK, NY 10022		2d Business code (see instructions)	Э	
					523900		
		nplete filing of this return/repor					
		alties set forth in the instructions, l he electronic version of this return					
	,						
SIGN	Filed with authorized/valid electr	onic signature.	10/11/2010	BARBARA JOSEFOWICZ	Z		
HERE							
	Signature of plan administra	tor	Date	Enter name of individual s	signing as plan administrator		
SIGN							
HERE							
	Signature of employer/plan s	ponsor	Date	Enter name of individual s	signing as employer or plan sp	onsor	
SIGN							
SIGN							

Signature of DFE Date Enter name
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2009) v.092307.1

Enter name of individual signing as DFE

Form 5500 (2009) Page <b>2</b>
--------------------------------

	Plan administrator's name and address (if same as plan sponsor, enter "Sar IG STREET CAPITAL MANAGEMENT, LP	me")		dministrator's EIN -3978904
	EAST 55TH STREET, 30TH FLOOR W YORK, NY 10022		ทเ	Iministrator's telephone Imber 2-812-3112
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for this plan, enter the name,	EIN and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	118
6	Number of participants as of the end of the plan year (welfare plans complete	te only lines <b>6a, 6b, 6c,</b> and <b>6d</b> ).		110
а	Active participants		<u>6a</u>	134
b	Retired or separated participants receiving benefits		6b	6
С	Other retired or separated participants entitled to future benefits		6с	
d	Subtotal. Add lines 6a, 6b, and 6c		6d	140
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits	6е	
f	Total. Add lines 6d and 6e		6f	140
g	Number of participants with account balances as of the end of the plan year complete this item)	•	6g	
h	Number of participants that terminated employment during the plan year wit less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only			
	If the plan provides pension benefits, enter the applicable pension feature of the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4H 4L			
9a	Plan funding arrangement (check all that apply)  (1)	9b Plan benefit arrangement (check al (1) X Insurance (2) Code section 412(e) (3) Trust (4) X General assets of th	(3) insurand	
10 a	Check all applicable boxes in 10a and 10b to indicate which schedules are a Pension Schedules  (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) H (Financial Infection of the content of t	formation) formation – nformation) vider Inform pating Plan	Small Plan) nation) Information)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2009

pursuant to ERISA section 103(a)(2).						
For calendar plan year 20	09 or fiscal plan	year beginning 01/01/2009	and e	nding 12/31/2	2009	
A Name of plan KING STREET CAPITAL	MANAGEMEN <sup>®</sup>	T WELFARE BENEFITS PLAN		e-digit number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500.  KING STREET CAPITAL MANAGEMENT, LP  D Employer Identification Number (E 13-3978904)  Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information Concerning Insurance Contract Coverage, Fees, and Commission Contract Coverage, Fees, Contract Coverage, Contract					n Number (EIN)	
			coverage, Fees, and Com unit in Parts II and III can be rep			
1 Coverage Information:						
(a) Name of insurance ca		E, INC.				
42 FIN	(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) Fro	m <b>(g)</b> To	
23-7391136	55093	504450	302	01/01/2009	12/31/2009	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid						
57265 26983						
<b>3</b> Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).						
	(a) Name a		or other person to whom commiss	sions or fees wer	e paid	
SKCG GROUP  123 MAIN STREET WHITE PLAINS, NY 10601						
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions paid		(c) Amount	(d) Purpose		(e) Organization code	
57265					3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
PROFESSIONAL GROUP PLANS  325 WIRELESS BLVD HAUPPAUGE, NY 11788						
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code	
		26983 BR	OKER		3	
For Donomucul, Doductio	n Act Notice o	nd OMP Control Numbers see	the instructions for Form FEOO		Sabadula A (Form FF00) 2000	

Schedule A (Form 5500)	2009	Page <b>2-</b> 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			
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	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for t	ourposes of
_		this report.			1
		ent value of plan's interest under this contract in the general account at year		<del></del>	
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	racts With Allocated Funds:			
	a	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		00	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ □	
7 (		racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	C
	d ·	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
		<b>)</b>			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		<b>7f</b>	

Page <b>4</b>		

	Schedule A	(Form	5500	2009
--	------------	-------	------	------

Pa	Part III Welfare Benefit Contract Informati					
	If more than one contract covers the same gree information may be combined for reporting put the entire group of such individual contracts we	rposes if such contracts	are experienc	e-rated as a unit. Whe	ere contracts	
8	Benefit and contract type (check all applicable boxes)					
	a X Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d Life insurance
	e Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>			h Rrescription drug
		j HMO contract	, s∟ k⊠		ioyinoni .	
	i ☐ Stop loss (large deductible)	I HIMO contract	κ	PPO contract		I Indemnity contract
	m ☐ Other (specify)					
9	Experience-rated contracts:					
9	a Premiums: (1) Amount received		02/1)			
	(2) Increase (decrease) in amount due but unpaid		9a(1) 9a(2)			
	(3) Increase (decrease) in unearned premium res		_ ;_;			
	(4) Earned ((1) + (2) - (3))	•			9a(4)	
	<b>b</b> Benefit charges (1) Claims paid	i	9b(1)		Ju(+)	
	(2) Increase (decrease) in claim reserves		(-)			
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
	(4) Claims charged				9b(4)	
	C Remainder of premium: (1) Retention charges (or				(-)	
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)	
	(2) Claim reserves					
	e Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in <b>c(2)</b> .)		9e	
10	Nonexperience-rated contracts:					
	a Total premiums or subscription charges paid to ca	10a	1573386			
	<b>b</b> If the carrier, service, or other organization incurred	401				
	retention of the contract or policy, other than repo	10b				
	Specify nature of costs					

Part IV	Provision of Information			
<b>11</b> 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.

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

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

						Inspection
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009	a	nd ending 12	2/31/2009	
A Name of plan KING STREET CAPITAL	MANAGEME	NT WELFARE BENEFITS PLAN		Three-digit plan number (P	N) •	501
C Plan sponsor's name a KING STREET CAPITAL				mployer Identific 3-3978904	cation Number (	EIN)
		ning Insurance Contract . Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca GUARDIAN LIFE INSURA		ANY OF AMERICA				
	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	of <b>(f</b> )	) From	<b>(g)</b> To
13-5123390	64246	358933	139	01/01/20	009	12/31/2009
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid						
7294						
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).						
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  N.M.P. PLANNING CO. INC.  92-25 QUEENS BLVD, 10TH FLOOR REGO PARK, NY 11374						
(b) Amount of sales ar	nd base	Fe	es and other commissions paid			
commissions paid		(c) Amount	(d) Purpose			(e) Organization code
	33		•			3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
SKCG GROUP INC.  123 MAIN STREET, 9TH FLOOR WHITE PLAINS, NY 10601-3104						
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	<b>(d)</b> Pu	rpose		(e) Organization code
	8414	7294 B	ROKER			3
						l .

Schedule A (Form 5500)	2009	Page <b>2-</b> 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			
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 indiv	ch carrier may be treated as a unit for t	ourposes of	
_		this report.			1
		ent value of plan's interest under this contract in the general account at year		<del></del>	
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	racts With Allocated Funds:			
	a	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		00	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ □	
7 (		racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	C
	d ·	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
		<b>)</b>			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		<b>7f</b>	

Page	4

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 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.

**Welfare Benefit Contract Information** 

Part III

8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental	c×	Vision		<b>d</b> X Life in	nsurance
	e [	Temporary disability (accident and sickness)	f X Long-term disability	y g 🗍	Supplemental unem	ployment	h Preso	ription drug
	iΓ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Inden	nnity contract
	m D	Other (specify) AD&D	,a saas.		1			inty contract
	··· <u>Ľ</u>	Other (specify)						
9 [	-xne	rience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)			_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	The state of the s	9a(3)				
		(4) Earned ((1) + (2) - (3))	<u>-</u>			. 9a(4)		
	_	Benefit charges (1) Claims paid	T T	9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (or	an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention				. 9c(1)(H)		
		$\begin{tabular}{ll} \end{tabular} \begin{tabular}{ll} \end{tabular} \beg$	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide by	penefits after	retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
		Dividends or retroactive rate refunds due. (Do no	t include amount entered	in <b>c(2)</b> .)		9e		
10	No	nexperience-rated contracts:						
		Total premiums or subscription charges paid to ca				. 10a		435251
	b	If the carrier, service, or other organization incurre			•	40h		
	_	retention of the contract or policy, other than repo	rted in Part I, item 2 abov	e, report amo	ount	10b		
	Эр	ecify nature of costs						
_	_							
Pa	rt I\	/ Provision of Information			<u>_</u>			
11	Dic	the insurance company fail to provide any informa	ation necessary to comple	ete Schedule	A?	Yes	X No	
12	If th	ne answer to line 11 is "Yes " specify the information	on not provided					

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

2009

Pension Benefit Guaranty Co	rporation	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				ending 12	/31/2009		
A Name of plan KING STREET CAPITAL	MANAGEMEN	T WELFARE BENEFITS PLAN		ee-digit n number (Pl	N) <b>•</b>	501	
C Plan sponsor's name a KING STREET CAPITAL			-	loyer Identific 978904	cation Number	(EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car CIGNA WORLDWIDE INS		MPANY					
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of	(6)	Policy or c		
	code	identification number	policy or contract year	(1)	From	<b>(g)</b> To	
23-2088429	90859	03295A	1 01/01/2		009	12/31/2009	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item	3 the agents	, brokers, and	other persons in	
(a) Total a	amount of comm		(b) <sup>-</sup>	Total amount	of fees paid		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	es needed to report all persons)			0	
• 1 Classia receiving confi		nd address of the agent, broker, o		ecione or fooc	wore paid		
THE PARKER GROUP	(a) Name a	123 M.	AIN STREET E PLAINS, NY 10601	SIONS OF TEES	, were раш		
(b) Amount of sales ar	nd base	Fees	s and other commissions paid				
commissions pai	d	(c) Amount	(d) Purpo	(d) Purpose		(e) Organization code	
	58					3	
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	sions or fees	were paid		
	(,	<u> </u>	·				
(b) Amount of sales and base Fees and other c		s and other commissions paid					
commissions pai		(c) Amount	(d) Purpo	se		(e) Organization code	

Schedule A (Form 5500)	2009	Page <b>2-</b> 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees 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			
	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 indiv	ch carrier may be treated as a unit for t	ourposes of	
_		this report.			1
		ent value of plan's interest under this contract in the general account at year		<del></del>	
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	racts With Allocated Funds:			
	a	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		00	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ □	
7 (		racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	C
	d ·	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
		<b>)</b>			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		<b>7f</b>	

Page <b>4</b>
loyer(s) or members of the same employe ence-rated as a unit. Where contracts co a unit for purposes of this report.

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	urposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contract	
8	Ben	efit and contract type (check all applicable boxes)	·				
	а	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f X Long-term disabilit	у <b>д</b> [		nlovment	h Prescription drug
	: [		j HMO contract	, s∟ k□	PPO contract	pioymoni	
	'	Stop loss (large deductible)	I HIVIO contract	N_	PPO contract		I Indemnity contract
	m	Other (specify)					
<u>a</u>	Evn	erience-rated contracts:					
9		Premiums: (1) Amount received	[	9a(1)			_
		(2) Increase (decrease) in amount due but unpaid	•	9a(2)			_
		(3) Increase (decrease) in unearned premium res		9a(3)			-
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		,	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	•	9c(1)(D)			_
		(E) Taxes	•	9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F) 9c(1)(G)			_
		(G) Other retention charges	•			0c/1\/H\	
		(H) Total retention	_			9c(1)(H)	
	a		<b>—</b> •				
	d	Status of policyholder reserves at end of year: (1 (2) Claim reserves				9d(1) 9d(2)	
		(3) Other reserves				9d(2)	
	е	Dividends or retroactive rate refunds due. (Do no				. 9a(3) . 9e	
10		nexperience-rated contracts:	or morado dimodrit omorod	· · · · · · · · · · · · · · · · · · ·		·1 00	
	а	Total premiums or subscription charges paid to c	arrier			. 10a	676
	b	If the carrier, service, or other organization incurr					
		retention of the contract or policy, other than repo	, ,		•	. 10b	
	Sp	pecify nature of costs					

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

Schedule A (Form 5500) 2009

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

2009

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	9	and er	nding 12	/31/2009			
A Name of plan KING STREET CAPITAL	MANAGEME	NT WELFARE BENEFITS PLAI	N		e-digit number (Pl	N) •	501
C Plan sponsor's name a KING STREET CAPITAL				<b>D</b> Emplo	-	ation Number	(EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		JRANCE					
			(e) Approximate no	ımber of		Policy or c	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	<b>(g)</b> To
06-0303370	62308	03295A	1		01/01/20	009	12/31/2009
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in
(a) Total a	amount of cor	nmissions paid		<b>(b)</b> To	otal amount	of fees paid	
		1527					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
• r ereene recenning com		and address of the agent, broke			ions or fees	were paid	
THE PARKER GROUP	(1)	123	MAIN STREET ITE PLAINS, NY 10601				
		F	ees and other commission	ne naid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose		(e) Organization code	
·	1527	(1)					3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	. ,	<i>y</i> ,	,			•	
(b) Amount of sales and base Fees and other commis			ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code

Schedule A (Form 5500)	2009	Page <b>2-</b> 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees 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			
	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 indiv	ch carrier may be treated as a unit for t	ourposes of	
_		this report.			1
		ent value of plan's interest under this contract in the general account at year		<del></del>	
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	racts With Allocated Funds:			
	a	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		00	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ □	
7 (		racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	C
	d ·	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
		<b>)</b>			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		<b>7f</b>	

Schedule A (Form 5500) 2009		Page <b>4</b>						
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 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.								
and contract type (check all applicable boxes)								
lealth (other than dental or vision)	<b>b</b> X Dental	<b>c</b> Vision	<b>d</b> X Life insurance					
emporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug					
Stop loss (large deductible)	j HMO contract	<b>k</b> ☐ PPO contract	I Indemnity contract					
Other (specify) AD&D EVACUATION	_	<del>_</del>						

	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у <b>д</b>	Supplemental unemp	oloyment	h Prescription drug
	iΓ	Stop loss (large deductible)	j HMO contract	,	PPO contract	•	I Indemnity contract
	m [	Other (specify) AD&D EVACUATION	, I mile contract	• _	110001111101		I macming contract
	[	Other (specify)					
9 E	Ехрє	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpai		9a(2)			
		(3) Increase (decrease) in unearned premium re-	serve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (	on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes	li de la companya de	9c(1)(E)			
		(F) Charges for risks or other contingencies					
		(G) Other retention charges				T	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)					
	d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement					
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)					
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to	carrier			10a	19084
	<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or					401	
		retention of the contract or policy, other than rep	orted in Part Litem 2 abov	/e. report am	ount	10b	

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

Specify nature of costs >

8 Benefit and contract type (check all applicable boxes)

Part III

#### 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 and ending					d ending			
			an;	a multipl	e-employer plan; or			
			a DFE (s	pecify)				
Вт	his return/report is:	X the first return/rep	ort;	the final	return/report;			
		an amended return	n/report;	a short p	olan year return/report (less than 12 months).			
C If	the plan is a collectively-		re	<u></u>	<b>.</b>			
D c	heck box if filing under:	X Form 5558;		automatic extension; the DFVC program;				
	special extension (enter description)							
Part	<u> </u>	ormation - enter all re	equested information		· · · · · · · · · · · · · · · · · · ·			
	Name of plan				1b Three-digit			
KING		TAL MANAGEME	NT WELFARE E	BENEFITS	plan number (PN) ▶ 501			
PLAN					1c Effective date of plan			
	·····				01/01/1998			
	Plan sponsor's name and Address should include ro		a single-employer plan)		2b Employer Identification			
		·	Nm TD		Number (EIN)			
	STREET CAPI'				13-3978904			
	CAST 55TH STR				2c Sponsor's telephone			
NEW	YORK	IN I I	0022		number 212-812-3112			
					2d Business code (see			
					instructions) 523900			
					323900			
Causi	on. A constru for the late	or incomplete filing o	f this raturn/ranget will b	o accorred unless re	easonable cause is established.			
	<del> </del>			···	· · · · · · · · · · · · · · · · · · ·			
statem	penalties of perjury and officients and attachments, as w	ell as the electronic versio	n of this return/report, and to	the best of my knowledg	n/report, including accompanying schedules, le and belief, it is true, correct, and complete.			
SIGN	Instru	<del>)</del>	/0/F/10	Miciwa P Newso 3/2  Enter name of individual signing as plan administrator				
11	Signature of plan admir	nistrator	Date	Enter name of individual signing as plan administrator				
SIGN	//1/10			MICHARL P. WENDING				
	Signature of employer/	plan sponsor	Date	Enter name of individual signing as employer or plan sponsor				
SIGN HERE	U	,						
HENE	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") SAME  3b Adminis		3b Administra	rator's EIN				
SAI	ME	rator's telephone					
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for the	his plan, enter the name	· · · · · · · · · · · · · · · · · · ·	4b EIN			
	EIN and the plan number from the last return/report:	•	· · ·				
а	Sponsor's name	4c PN					
5	Total number of participants at the beginning of the plan year		5	118			
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b	, 6c, and 6d).	last.				
а	Active participants		6a	134			
b	Retired or separated participants receiving benefits		6b	6			
С	Other retired or separated participants entitled to future benefits		6с	0			
d	Subtotal. Add lines 6a, 6b, and 6c		6d	140			
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	0				
f	Total. Add lines 6d and 6e	6f	140				
g	Number of participants with account balances as of the end of the plan year (only defined concomplete this item)	•	6g	0			
h	Number of participants that terminated employment during the plan year with accrued benefits less than 100% vested	6h	0				
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plants)	7					
b	a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:  4A 4B 4D 4E 4H 4L						
9 a	· · · · · · · · · · · · · · · · · · ·	rrangement (check all t	hat ap	ply)			
		(1) X Insurance		acuranca contracto			
		(2) Code section 412(e)(3) i (3) Trust		insurance contracts			
	V	\-'\		onsor			
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						
а	Pension Schedules b General Schedules						
		Financial Information)					
		inancial Information – S	Small Plan)				
	IVI A	Insurance Information)		•			
		Service Provider Inform	ation)				
		DFE/Participating Plan	Inforr	nation)			
	Information) - signed by the plan actuary (6) G (	Financial Transaction S	chedu	les)			