Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

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

					Inspection	
Part I	Annual Report Ident					
For cale	ndar plan year 2009 or fiscal pl	an year beginning 01/01/2	2009	and ending 1	2/31/2009	
A This	return/report is for:	a multiemployer plan	; a multip	le-employer plan; or		
		a single-employer pla	an; a DFE ((specify)		
		_	_			
B This	return/report is:	the first return/report	the fina	I return/report;		
		an amended return/re	eport; a short	plan year return/report (less than 12 months).	
C If the	plan is a collectively-bargained	d plan, check here				
D Chec	k box if filing under:	X Form 5558;	automa	tic extension;	the DFVC program;	
		special extension (er	nter description)			
Part	II Rasic Plan Inform	ation—enter all requested				
	ne of plan	ation onto an requested	monnation		1b Three-digit plan	
	YARDS BANK AND TRUST C	OMPANY WELFARE PLAN			number (PN) ▶ 504	
					1c Effective date of plan	
3 0 Dis		/	-1		01/01/1998	
	n sponsor's name and address Iress should include room or su		ployer plan)		2b Employer Identification Number (EIN)	
`	YARDS BANK AND TRUST C	,			61-0354170	
					2c Sponsor's telephone	
LINDSA	Y GABBARD				number 502-625-9133	
PO BOX			BOX 32890		2d Business code (see	
LOUISV	ILLE, KY 40232	LO	UISVILLE, KY 40232	instructions)		
					522110	
Caution	: A penalty for the late or inc	omplete filing of this retur	n/report will be assessed	l unless reasonable ca	use is established.	
			•		eport, including accompanying schedules,	
stateme	nts and attachments, as well as	the electronic version of thi	s return/report, and to the	best of my knowledge a	nd belief, it is true, correct, and complete.	
SIGN	Filed with authorized/valid elec	ctronic signature.	10/15/2010	LINDSAY GABBAR	ı	
HERE Signature of plan administrate		ator	Date	Enter name of indivi	dual signing as plan administrator	
					- ·	
SIGN						
HERE	Signature of employer/plan	sponsor	Date	Enter name of indivi	dual signing as employer or plan sponsor	
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•				
SIGN						
HERE	1		+	1		

Date

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)	F	Page 2	2		
STO LIN PO	STOCK YARDS BANK AND TRUST COMPANY			3b Administrator's EIN 61-0354170 3c Administrator's telephone number 502-625-9133		
4 a	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: Sponsor's name	port filed fo	or this	plan, enter the name, EIN	I and	4b EIN 4c PN
5	Total number of participants at the beginning of the plan year				5	466
6	Number of participants as of the end of the plan year (welfare plans complete or	nly lines 6	a, 6b,	6c, and 6d).		
а	Active participants				. 6a	538
b	Retired or separated participants receiving benefits				. 6b	
С	Other retired or separated participants entitled to future benefits				. 6с	
d	Subtotal. Add lines 6a, 6b, and 6c				. 6d	538
е	Deceased participants whose beneficiaries are receiving or are entitled to receiv	ve 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 (on complete this item)				. 6g	
h	Number of participants that terminated employment during the plan year with acless than 100% vested				. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only mu	ultiemploye	er plar	ns complete this item)	. 7	
b 1	If the plan provides pension benefits, enter the applicable pension feature codes If the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from the plan provides	om the Lis	t of P		at apply)	tructions:

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

b General Schedules

(1)

(2)

(3)

(4)

(5)

(6)

H (Financial Information)

12 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

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

For calendar plan year 200	09 or fiscal plan	year beginning 01/01/2009	and e	ending 12/31/2009	•		
A Name of plan			B Thr				
STOCK YARDS BANK A	ND TRUST CO	MPANY WELFARE PLAN	pla	plan number (PN) 504			
C Plan sponsor's name a	C Plan sponsor's name as shown on line 2a of Form 5500. D Employer Identification Number (I						
STOCK YARDS BANK AND TRUST COMPANY 61-0354170							
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
COLONIAL LIFE & ACCII	DENT INSURAI	NCE CO					
	1	T		Dellacon			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	-	contract year		
	code	identification number	policy or contract year	(f) From	(g) To		
57-0144607	62049	E3080561	20	01/01/2009	12/31/2009		
2 Insurance fee and com- descending order of the		tion. Enter the total fees and total	I commissions paid. List in item	3 the agents, brokers, and	other persons in		
	amount of comm	nissions paid	(b) 1	Total amount of fees paid			
(4)		328	(10)	Fare	79		
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons).				
		nd address of the agent, broker,		sions or fees were paid			
MICHAEL BOONE		10200	FOREST GREEN BLVD	•			
		LOUIS	SVILLE, KY 40223				
(h) Amount of color or		Fee	s and other commissions paid				
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpo	se	(e) Organization code		
	118	79			, ,		
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	sions or fees were paid			
REISERT & ASSOCIATE	S)X 5399	•			
		LOUIS	VILLE, KY 40255				
		Fee	s and other commissions paid		1		
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpo	se.	(e) Organization code		
commissions put	97	(b) / anount	(a) 1 dipo		(5) 5.8324.011 0040		
	·						
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500). Sci	hedule A (Form 5500) 2009 v.092308.1		

Schedule A (Form 5500) 2	.009	Page 2- 1			
	me and address of the agent, br	oker, or other person to whom commissions or fees were pai	d		
TED BENNETT		330 DESTINY LANE DWLING GREEN, KY 42304			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
63					
(a) Na	me and address of the agent, hi	oker, or other person to whom commissions or fees were pai	d		
VICKIE LEWIS	65	558 STOVALL RD AVE CITY, KY 42127	u		
(b) Amount of sales and base		Fees and other commissions paid	(a) Organization		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
21					
(a) Na	me and address of the agent, hi	oker, or other person to whom commissions or fees were pai	d		
DEE ANN SLADE	10	04 POTOMAC CT RANKFORT, KY 40601	u		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
11					
(a) No.	me and address of the agent by	relear or other person to whom commissions or feet were not			
SHOLANDA JANE ALLEN	16	oker, or other person to whom commissions or fees were pai 881 BALLARDSVILLE RD AWENCEBURG, KY 40342	u		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
8					
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were pai	d		
LISA GRAVES	14	100 GLENNS CREEK RD RANKFORT, KY 40601			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
6					
		•	<u> </u>		

Schedule A	(Form 5500)	2000
Scriedule A	(F01111 5500)	2009

- 2

(a) Na	ime and address of the agent, broke	r, or other person to whom commissions or fees were paid		
MARK HOLLAND		OX 38306 MANTOWN, TN 38183		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
4				
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code	
	(0)////	(a) · dipoco		
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid (c) Amount (d) Purpose code				

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Schedule A (Form 5500) 2009		Page 4	
	ame group of employees of the tring purposes if such contract	cts are experience-rated as a unit. V	the same employee organization(s), the Where contracts cover individual employe his report.
and contract type (check all applicable b	ooxes)		
lealth (other than dental or vision)	b Dental	C Vision	d Life insurance

		information may be combined for reporting put the entire group of such individual contracts with the entire group of the entir					s cover individual employees	,
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	<u> </u>	Supplemental unemp		h Prescription drug	
	i į̇̃	Stop loss (large deductible)	j HMO contract	k [PPO contract	-	I Indemnity contract	
	m	Other (specify) CANCER	_	_	-		—	
	_	_						
9	Ехре	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	ł	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid						
		(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					_	
		(C) Other specific acquisition costs					_	
		(D) Other expenses		9c(1)(D)				
		(E) Taxes					_	
		(F) Charges for risks or other contingencies.						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in c(2) .)		9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to o	arrier			10a	37	45
	b	If the carrier, service, or other organization incurr	, ,		'	10h		
	_	retention of the contract or policy, other than repo	orted in Part I, item 2 above	ve, report am	ount	10b		
	Sp	pecify 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

For calendar plan year 2009 or fiscal plan year beginning

Insurance Information

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

File as an attachment to Form 5500.

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

and ending

12/31/2009

01/01/2009

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

A Name of plan STOCK YARDS BANK AND TRUST COMPANY WELFARE PLAN				Three-o	digit umber (PN)	504
				•	,	
C Plan sponsor's name a STOCK YARDS BANK A				mploye 1-0354	er Identification Number 170	(EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca		NCE CO				
(1) FIN	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or o	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From	(g) To
57-0144607	62049	E7760994	20		01/01/2009	12/31/2009
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. List in it	tem 3 th	he agents, brokers, and	other persons in
(a) Total a	amount of comn		((b) Tota	al amount of fees paid	
		383				74
3 Persons receiving com		es. (Complete as many entries a				
MICHAEL BOONE	(a) Name a	nd address of the agent, broker, o	or other person to whom com FOREST GREEN BLVD	nmissio	ns or fees were paid	
MICHAEL BOONE			NCEBURG, KY 40223			
		Foor	s and other commissions paid	d		
(b) Amount of sales ar commissions pa		(c) Amount		u irpose		(e) Organization code
	160	74	(a) i dipose			(-,g
	(a) Name a	nd address of the agent, broker, o	or other person to whom com	nmissio	ns or fees were paid	
REISERT & ASSOCIATE		PO BC)X 5399 VILLE, KY 40255		•	
(b) Amount of sales and base			and other commissions paid	d		
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	111					
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5	5500.	Sc	hedule A (Form 5500) 2009

Schedule A (Form 5500) 2	009	Page 2- 1	
	me and address of the agent, bro	oker, or other person to whom commissions or fees were pa	id
TED BENNETT	183	30 DESTINY LANE OWLING GREEN, KY 42104	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
53			
(a) Na			.,
LISA GRAVES	140	oker, or other person to whom commissions or fees were pa 00 GLENNS CREEK RD	Id
	FR	ANKFORT, KY 40601	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
16	(c) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pa	id
VICKIE LEWIS	655	58 STOVALL RD VE CITY, KY 42127	-
	CA	WE 0111, KT 42127	
(b) Amount of sales and base	Fees and other commissions paid		(e) Organization code
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pa	id
SHOLANDA JANE ALLEN	168	81 BALLARDSVILLE RD	iu .
	LA	WENCEBURG, KY 40342	
(b) Amount of sales and base	Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nia	and address of the count has		:
DEE ANN SLADE	104	oker, or other person to whom commissions or fees were pa 4 POTOMAC CT	iu .
	FR	ANKFORT, KY 40601	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 8	(c) Amount	(d) Purpose	code
8			

Schedule A	(Form	5500	2009
Ochicadic A	(1 01111	3300	, 2003

Page 2-	2	
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MARK HOLLAND	RK HOLLAND PO BOX 38366 GERMANTOWN, TN 38183				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid 8	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, broker	r, or other person to whom commissions or fees were paid			
WENDY CASE	118 PF LOUIS	ROMENADE CT SVILLE, KY 40223			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid 3	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, broker	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, broker	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization code		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, broker	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization code		
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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		

9d(3)

9e

10a

10b

4524

	Schedule A (Form 5500) 2009		Р	age 4	<u>—</u>	
Part III	Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts	roup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Who	ere contracts	
8 Benef	it and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	b Dental	С	Vision	d	Life insurance
е 🗍	Temporary disability (accident and sickness)	f Long-term disability	v a	Supplemental unemp	ployment h	Prescription drug
iΠ	Stop loss (large deductible)	i HMO contract		PPO contract	, ,	Indemnity contract
. □	, , ,	, I into contract		11 0 contract		I I indemnity contract
m 📙	Other (specify)					
9 Evperi	ence-rated contracts:					
•	emice-rated contracts. emiums: (1) Amount received	Г	9a(1)			
	2) Increase (decrease) in amount due but unpai	F	9a(2)			
,	B) Increase (decrease) in unearned premium res	T T	9a(3)			
	l) Earned ((1) + (2) - (3))	_	. , ,		9a(4)	
	Benefit charges (1) Claims paid		9b(1)		1 55(1)	
	2) Increase (decrease) in claim reserves	-	9b(2)			
	B) Incurred claims (add (1) and (2))				9b(3)	
,	l) Claims charged				9b(4)	
C F	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		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	2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)	9c(2)	
d 8	Status of policyholder reserves at end of year: (1	I) Amount held to provide t	penefits after	retirement	9d(1)	
(2) Claim reserves				9d(2)	

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

a Total premiums or subscription charges paid to carrier

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

	,	,	0	, ,			•
retention	of the co	ntract or	policy, other	than reported in P	art I, item 2 above,	report amount	
Specify nati	ure of cost	s 🕨					

10 Nonexperience-rated contracts:

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

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	m is Open to Public Inspection			
For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/2009	9	and er	nding 12	/31/2009	
A Name of plan STOCK YARDS BANK A	ND TRUST C	OMPANY WELFARE PLAN			e-digit number (PN	N) •	504
C Plan sponsor's name a STOCK YARDS BANK A				D Emplo	-	ation Number	(EIN)
	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							
	1	T			Т		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a		(5)		ontract year
	code	identification number	policy or contrac	t year	(1)	From	(g) To
93-0242990	69019	143865	44	12	04/01/20	08	03/31/2009
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in item 3	the agents,	, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		11099					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		and address of the agent, broke		m commiss	ions or fees	were paid	
REISERT & ASSOCIATE	S		5 BARDSTOWN RD JISVILLE, KY 40204				
							_
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	11099						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	·						
(b) Amount of sales ar			ees and other commission				(a) Onnania di la cara
commissions pa	Ia	(c) Amount		(d) Purpose	е		(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page	4

Schedule A	(Form	5500	2000
Scriedule A	LEOHII	5500	1 ZUU3

a Health (other e Temporary i Stop loss (la m Other (special a Premiums: (1) (2) Increase ((3) Increase ((4) Earned ((1) b Benefit charg (2) Increase ((3) Incurred c (4) Claims chard c Remainder of (A) Comm (B) Admin (C) Other (D) Other	arge deductible) ify) •	erve	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	PPO contract	71539 9a(4) 1769 9b(3)	d X Life insurance h Prescription drug I Indemnity contract 71539
e Temporary i Stop loss (la m Other (special a Premiums: (1) (2) Increase ((3) Increase ((4) Earned ((1) b Benefit charge (2) Increase ((3) Incurred ce (4) Claims charge (A) Comme (B) Admin (C) Other (D) Other	disability (accident and sickness) arge deductible) ify) contracts: Amount received	f Long-term j HMO contr	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	Supplemental PPO contract	71539 9a(4) 1769 9b(3) 9b(4)	h Prescription drug I Indemnity contract
i Stop loss (la m Other (special of the control of	arge deductible) ify) contracts: Amount received	j HMO contr	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	PPO contract	71539 9a(4) 1769 9b(3) 9b(4)	I Indemnity contract
9 Experience-rated of a Premiums: (1) (2) Increase (3) Increase (4) Earned (7) b Benefit charge (2) Increase (3) Incurred of (4) Claims charge (A) Commercial (B) Administration (C) Other (D) Other	contracts: Amount received	erven an accrual basis	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)		9a(4) 1769 9b(3) 9b(4)	71539
9 Experience-rated of a Premiums: (1) (2) Increase ((3) Increase ((4) Earned ((1) b Benefit charge (2) Increase ((3) Incurred of (4) Claims charge (4) Claims charge (A) Comme (B) Administration (C) Other (D) Other	contracts: Amount received	erve n an accrual basis	9a(2) 9a(3) 9b(1) 9b(2) 9c(1)(A)		9a(4) 1769 9b(3) 9b(4)	
a Premiums: (1) (2) Increase ((3) Increase ((4) Earned ((1) b Benefit charg (2) Increase ((3) Incurred c (4) Claims charg (A) Comm (B) Admir (C) Other (D) Other	Amount received	erve n an accrual basis	9a(2) 9a(3) 9b(1) 9b(2) 9c(1)(A)		9a(4) 1769 9b(3) 9b(4)	
a Premiums: (1) (2) Increase ((3) Increase ((4) Earned ((1) b Benefit charg (2) Increase ((3) Incurred c (4) Claims charg (A) Comm (B) Admir (C) Other (D) Other	Amount received	erve n an accrual basis	9a(2) 9a(3) 9b(1) 9b(2) 9c(1)(A)		9a(4) 1769 9b(3) 9b(4)	
(3) Increase ((4) Earned ((1) b Benefit charg (2) Increase ((3) Incurred c (4) Claims charg c Remainder o (A) Comm (B) Admin (C) Other (D) Other	decrease) in unearned premium reso) + (2) - (3))	n an accrual basis	9a(2) 9a(3) 9b(1) 9b(2) 9c(1)(A)		1769 9b(3) 9b(4)	
(3) Increase ((4) Earned ((1) b Benefit charg (2) Increase ((3) Incurred c (4) Claims charg c Remainder o (A) Comm (B) Admin (C) Other (D) Other	decrease) in unearned premium reso) + (2) - (3))	n an accrual basis	9a(3) 9b(1) 9b(2) 9b(2) 9c(1)(A)		1769 9b(3) 9b(4)	
(4) Earned ((1) b Benefit charg (2) Increase ((3) Incurred c (4) Claims charge c Remainder of (A) Comm (B) Admin (C) Other (D) Other) + (2) - (3)) es (1) Claims paid decrease) in claim reserves aims (add (1) and (2)) premium: (1) Retention charges (or hissions	n an accrual basis	9b(1) 9b(2)		1769 9b(3) 9b(4)	
(2) Increase ((3) Incurred c (4) Claims chi C Remainder o (A) Comm (B) Admir (C) Other (D) Other	decrease) in claim reservesaims (add (1) and (2))arged	n an accrual basis	9b(2) 		9b(3) 9b(4)	
(3) Incurred c (4) Claims cha C Remainder o (A) Comm (B) Admir (C) Other (D) Other	aims (add (1) and (2))arged	n an accrual basis	9c(1)(A)		9b(3) 9b(4)	
(4) Claims character of Remainder of (A) Comm (B) Admir (C) Other (D) Other	arged premium: (1) Retention charges (or nissions	n an accrual basis	9c(1)(A)		9b(4)	1769
C Remainder of (A) Comm (B) Admir (C) Other (D) Other	premium: (1) Retention charges (or nissions	n an accrual basis	s) <mark>9c(1)(A)</mark>	_		
(A) Comr (B) Admir (C) Other (D) Other	nissions nistrative service or other fees		9c(1)(A)		11000	
(B) Admir (C) Other (D) Other	istrative service or other fees				11/100	7
(C) Other (D) Other			9c(1)(B)		11099	
(D) Other	specific acquisition costs		0-(4)(0)	-		_
` ,			2 (1)(2)		6322	_
	expenses				1073	
()			2 (1)(=)		5008	_
	es for risks or other contingencies				46268	_
	retention charges				2 (1)(1)	69770
` '	retention	_				03770
	or retroactive rate refunds. (These		<u> </u>			
·	cyholder reserves at end of year: (1)	•				14449
()	erves					14449
` '	erves				` ` `	+
e Dividends or 10 Nonexperience-r	retroactive rate refunds due. (Do no	or include amount	entered in C(2) .)	•••••	9e	
•		arrior			10a	
retention of the contract or policy, other than reported in Part I, item 2 above, report amount						
Specify nature o					<u> </u>	

Yes

Provision of Information

Part IV

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). This Form is Open to Public Inspection						
For calendar plan year 200	09 or fiscal plar	n year beginning 01/01/2009	and	ending 12	/31/2009	
A Name of plan STOCK YARDS BANK AI	ND TRUST CO	MPANY WELFARE PLAN		ee-digit n number (Pl	N) •	504
C Plan sponsor's name a STOCK YARDS BANK AI			-	loyer Identific 354170	cation Number ((EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	ANCE CO LTD	1	(e) Approximate number of	T	Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f)	From	(g) To
93-0242990	69019	143865	442	04/01/20	008	03/31/2009
2 Insurance fee and composite descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item	3 the agents	, brokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
2		13362				0
Persons receiving com		ees. (Complete as many entries a		. ,		
REISERT & ASSOCIATE			or other person to whom commis BARDSTOWN RD VILLE, KY 40204	ssions or rees	s were paid	
(b) Amount of sales ar	nd base	Fees	s and other commissions paid			
commissions pai		(c) Amount	(d) Purpo	se		(e) Organization code
	13362					
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	sions or fees	were paid	
	(a) Name a	and address of the agent, broker, t	or early person to whom commis	310113 01 1000	were paid	
(b) Amount of sales ar	nd hase	Fees	s and other commissions paid			
commissions pai		(c) Amount	(d) Purpo	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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Pa	qе	4

Part III Welfare Benefit Contract Information

e Temporary disability (accident and sickness) i Stop loss (large deductible) j HMO contract k PPO contract l Indemnity or m Other (specify) 9 Experience-rated contracts: a Premiums: (1) Amount received		- 1 - "	o. pa.poooo oo	eated as a ur	er may be tre	urposes if such o with each carrier	h individual contracts	the entire group of such		
e Temporary disability (accident and sickness) i Stop loss (large deductible) j HMO contract k PPO contract l Indemnity or m Other (specify) Experience-rated contracts: a Premiums: (1) Amount received	7)	k all applicable boxes)	fit and contract type (check	B ene	8
i	Life insurance	C	Vision	С		b Dental	or vision)	Health (other than dental	а	
i	Prescription drug	ployment h	Supplemental unemp	g⊟	rm disability	f X Long-terr			e	
### Dither (specify) ### Disperience-rated contracts: ### A Premiums: (1) Amount received	Indemnity contract		PPO contract		ntract	i HMO con			ιČ	
9 Experience-rated contracts: a Premiums: (1) Amount received	_ macminity contract	'		🗀		,	,	· -	m	
a Premiums: (1) Amount received								[· · · · · · · · · · · · · · · · · · ·	<u>L</u>	
(2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearned premium reserve								rience-rated contracts:	Ехре	9
(3) Increase (decrease) in unearned premium reserve		86107		9a(1)			ived	remiums: (1) Amount recei	a	
(4) Earned ((1) + (2) - (3))				9a(2)		d	amount due but unpai	2) Increase (decrease) in a		
b Benefit charges (1) Claims paid				9a(3)		serve	unearned premium re	3) Increase (decrease) in u		
(2) Increase (decrease) in claim reserves	86107	. 9a(4)						(4) Earned ((1) + (2) - (3))		
(2) Incurred claims (add (1) and (2))							paid	Benefit charges (1) Claims	b	
(4) Claims charged				9b(2)			claim reserves	2) Increase (decrease) in o		
C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions 9c(1)(A) 13362 (B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(D) 9810 (E) Taxes 9c(1)(E) 1292 (F) Charges for risks or other contingencies 9c(1)(F) 10333 (G) Other retention charges 9c(1)(G) 48717 (H) Total retention 9c(1)(H) 9c(1	2593						• • • •	, , , ,		
(A) Commissions 9c(1)(A) 13362 (B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(D) 9810 (E) Taxes 9c(1)(E) 1292 (F) Charges for risks or other contingencies 9c(1)(F) 10333 (G) Other retention charges 9c(1)(G) 48717 (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (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).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or		. 9b(4)						· ·		
(B) Administrative service or other fees		40000			<i>'</i>		, ,	. ,	С	
(C) Other specific acquisition costs		13362								
(D) Other expenses 9c(1)(D) 9810 (E) Taxes 9c(1)(E) 1292 (F) Charges for risks or other contingencies 9c(1)(F) 10333 (G) Other retention charges 9c(1)(G) 48717 (H) Total retention 9c(1)(H) 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (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).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or								` '		
(E) Taxes		0810						. ,		
(F) Charges for risks or other contingencies 9c(1)(F) 10333 (G) Other retention charges 9c(1)(G) 48717 (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (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).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or								` '		
(G) Other retention charges								` '		
(H) Total retention					—		ŭ	` ,		
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (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).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or	83514				_		ŭ	` '		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	00014			_		-				
(2) Claim reserves						-			الم	
(3) Other reserves	32381				•	•	,	• •	a	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier	32301									
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier								` '	•	
a Total premiums or subscription charges paid to carrier		. 9e		n c(2) .)	unt entered i	ot include amour				11
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or		100				corrior				''
							_			
retention of the contract or policy, other than reported in Part I, item 2 above, report amount							D			
Specify nature of costs				, . ,		,	, , ,		Sp	

X No

Yes

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

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). This Form is Open to Public Inspection							
For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/2009	9	and en	ding 12	/31/2009	
A Name of plan STOCK YARDS BANK AI		B Three plan	e-digit number (PI	N) •	504		
C Plan sponsor's name a STOCK YARDS BANK A				D Employ 61-035		ation Number (EIN)
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	ITUCKY	(d) Control of	(e) Approximate nu	umber of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year		(f)	From	(g) To
61-0659432	54674	000686300	, ,	460 01/01/2		09	12/31/2009
2 Insurance fee and complete descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents	brokers, and o	ther persons in
(a) Total a	amount of con	nmissions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie		persons).			0
• 1 Greens receiving com		and address of the agent, broke			ons or fees	were naid	
REISERT INSURANCE	(a) Name	122	25 BARDSTOWN RD UISVILLE, KY 40204	11 00111111001	0110 01 1000	were pare	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
		(e) Organization code					
	12199						
	(a) Name	and address of the agent, broke	er, or other person to whor	m commissi	ons or fees	were paid	
	(2)	J. J					
(b) Amount of sales ar			ees and other commission		-		(a) Onna institute and
commissions pa	iu	(c) Amount		(d) Purpose			(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4	

Pä	If more than one contract covers the		same employ	er(s) or members of the sa	ame empl	ovee organization(s), the
	information may be combined for rep the entire group of such individual co	porting purposes if such contracts	s are experienc	ce-rated as a unit. Where	contracts	
8	Benefit and contract type (check all applicabl	e boxes)				
	a Health (other than dental or vision)	b X Dental	С	Vision	c	Life insurance
	e Temporary disability (accident and sick	kness) f Long-term disabi	ility g	Supplemental unemploy	ment ľ	Prescription drug
	i Stop loss (large deductible)	j HMO contract	, s_ k□	PPO contract		I Indemnity contract
	m Other (specify) ▶	j 🗌 i ilvio contract	~_] FFO contract		I Indemnity contract
	III Other (specify)					
9	Experience-rated contracts:					
	a Premiums: (1) Amount received		9a(1)		123768	
	(2) Increase (decrease) in amount due b	out unpaid				
	(3) Increase (decrease) in unearned pre-					
	(4) Earned ((1) + (2) - (3))				9a(4)	123768
	b Benefit charges (1) Claims paid		9b(1)		113903	
	(2) Increase (decrease) in claim reserves	s	9b(2)		6492	
	(3) Incurred claims (add (1) and (2))				9b(3)	120395
	(4) Claims charged				9b(4)	120395
	c Remainder of premium: (1) Retention ch	narges (on an accrual basis)				
	(A) Commissions		9c(1)(A)		12199	
	(B) Administrative service or other fe	ees	9c(1)(B)		16038	
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses					
	(E) Taxes					
	(F) Charges for risks or other conting	gencies				
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention			90	c(1)(H)	28237
	(2) Dividends or retroactive rate refunds	. (These amounts were paid	in cash, or	credited.)	9c(2)	
	d Status of policyholder reserves at end or	f year: (1) Amount held to provide	e benefits after	retirement	9d(1)	
	(2) Claim reserves				9d(2)	6492
	(3) Other reserves				9d(3)	
	e Dividends or retroactive rate refunds du	e. (Do not include amount entere	ed in c(2) .)		9e	
10	Nonexperience-rated contracts:					
	a Total premiums or subscription charges	paid to carrier			10a	
	b If the carrier, service, or other organizati retention of the contract or policy, other	, .		•	10b	
	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	

¹² If the answer to line 11 is "Yes," specify the information 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

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				n is Open to Public Inspection			
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/200	9	and en	iding 12	/31/2009	
A Name of plan	•	OMPANY WELFARE PLAN		B Three			504
C Plan sponsor's name a STOCK YARDS BANK AI				D Employer Identification Number (EIN) 61-0354170			
	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	rrier	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To
61-1105118	48127	000686300	, ,	68		09	12/31/2009
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all I	persons).			0
		and address of the agent, broke			ons or fees	were paid	
REISERT INSURANCE		122	5 BARDSTOWN RD JISVILLE, KY 40204			·	
(b) Amount of sales ar	nd hase	F	ees and other commissior	ns paid			
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code
	1400						
	(a) Name	and address of the agent, broke	er, or other person to whor	n commissi	ons or fees	were paid	
(b) Amount of sales ar			ees and other commission		<u> </u>		
commissions pai	d	(c) Amount		(d) Purpose	9		(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

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Pa	art I	Welfare Benefit Contract Informati	on				
		If more than one contract covers the same gro information may be combined for reporting put the entire group of such individual contracts w	rposes if such co	ontracts are experier	nce-rated as a unit. W	here contracts/	
8	Ber	nefit and contract type (check all applicable boxes)	_				_
	а	Health (other than dental or vision)	b X Dental	С	Vision	•	d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term	disability g	Supplemental uner	mployment l	h Prescription drug
	i	Stop loss (large deductible)	j HMO cont	ract k	PPO contract		I Indemnity contract
	m	Other (specify)	• 🗆				
	!						
9	Ехр	erience-rated contracts:					
	a	Premiums: (1) Amount received		9a(1)		13600	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))		<u></u>		9a(4)	13600
	b	Benefit charges (1) Claims paid		9b(1)		5476	
		(2) Increase (decrease) in claim reserves		9b(2)		248	
		(3) Incurred claims (add (1) and (2))				9b(3)	5724
		(4) Claims charged				9b(4)	5724
	С	Remainder of premium: (1) Retention charges (or	an accrual basi	s)		_	
		(A) Commissions		9c(1)(A)		1400	
		(B) Administrative service or other fees		9c(1)(B)		979]
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses					
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	2379
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to	provide benefits afte	er retirement	_ ` '	
		(2) Claim reserves				9d(2)	248
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount	t entered in c(2) .)			
10) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	
	b	If the carrier, service, or other organization incurre					
	retention of the contract or policy, other than reported in Part I, item 2 above, report amount						
	S	pecify 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

pursuant to ERISA section 103(a)(2).					This Fo	rm is Open to Public Inspection	
For calendar plan year 200	09 or fiscal pla	n year beginning 01/01/2009)	and endin	ng 12/31/2	2009	
A Name of plan STOCK YARDS BANK A	ND TRUST CO	OMPANY WELFARE PLAN	В		git mber (PN))	504
C Plan sponsor's name a STOCK YARDS BANK A	ND TRUST CO	DMPANY		61-035417			
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		ERICA					
<i>a</i> > =	(c) NAIC	(d) Contract or	(e) Approximate numb			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at er policy or contract ye		(f) Fro	om	(g) To
23-1503749	65498	FLX962134	151	(03/31/2008		04/01/2009
	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							
	2947						896
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all per	sons).			
<u> </u>		and address of the agent, broke			s or fees wer	re paid	
GREEN & HALLIBURTOI		521	BARRETT AVE JISVILLE, KY 40204			·	
(b) Amount of sales ar	nd hase	Fe	ees and other commissions p	aid			
commissions pa		(c) Amount	(d)	(d) Purpose			(e) Organization code
	2947	896					
	(a) Name a	and address of the agent, broke	r, or other person to whom c	ommissions	s or fees wer	re paid	
(b) Amount of sales ar	nd base	Fe	ees and other commissions p	aid			
commissions pa		(c) Amount	(d)	Purpose			(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4	
nployer(s) or members of the same en erience-rated as a unit. Where contracts is a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d \(\) Life insurar \(\) Prescription \(\) Indemnity \(\)

Pa	art III	Welfare Benefit Contract Informat	ion					
		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 v					is cover individual empl	лусса,
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	e =	Temporary disability (accident and sickness)	f Long-term disabili	ity g	Supplemental unem	ployment	h Prescription drug	
	i F	Stop loss (large deductible)	j HMO contract	, s_ k□	PPO contract		I Indemnity contract	·+
	m	Other (specify)		., _	110 contract		I ☐ Indemnity contract	·L
	m _	Other (specify)						
9	Expe	rience-rated contracts:						
Ī		remiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid	l	```				
		3) Increase (decrease) in unearned premium res		· · · · ·				
		(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						
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs						
		(D) Other expenses		9c(1)(D)				
		(E) Taxes						
		(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	□ '					
		Status of policyholder reserves at end of year: (1						
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do no	ot include amount entere	d in c(2) .)		. 9e		
10		experience-rated contracts:				40		20004
	_	Total premiums or subscription charges paid to c				10a		36004
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,		•	10b		
	Spe	ecify nature of costs						

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

Schedule A (Form 5500) 2009

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

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					•		
A Name of plan STOCK YARDS BANK AND TRUST COMPANY WELFARE F				Three-digit plan number (PN)	•	504	
C Plan sponsor's name as shown on line 2a of Form 5500. STOCK YARDS BANK AND TRUST COMPANY D Employer Identification Number (EIN) 61-0354170							
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		ERICA					
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	of (f) Fr	rom	(g) To	
23-1503749	65498	OK 963771	151 03/31/200			04/01/2009	
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							
	1077 342						
3 Persons receiving com	3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).						
<u> </u>					ere paid		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid GREEN & HALLIBURTON PO BOX 5399 LOUISVILLE, KY 40255							
(b) Amount of sales ar	nd hase	Fe	es and other commissions paid	d			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
1077		342				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 Fees and other commissions paid							
commissions pa		(c) Amount	(d) Pu	(d) Purpose			

Schedule A (Form 5500)					
(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	Fees and other commissions paid			
(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 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 ca	rrier may be treated as a unit fo	r purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	• 🗍	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accoun	ts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	• • •		
		(3) Interest credited during the year			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	- (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4	
loyer(s) or members	of the same employ
ence-rated as a unit.	Where contracts of
a unit for purposes of	this report.

X No

Yes

If more than one contract covers the same group of employees of information may be combined for reporting purposes if such contr the entire group of such individual contracts with each carrier may	acts are experienc	ce-rated as a unit. Where con	tracts cover individual employees,
8 Benefit and contract type (check all applicable boxes)			
a ☐ Health (other than dental or vision) b ☐ Dental	С	Vision	d X Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term dis	sability g	Supplemental unemployme	불
i ☐ Stop loss (large deductible) j ☐ HMO contrac	t k	PPO contract	I Indemnity contract
m ☐ Other (specify) ▶]	- I madining definition
III Utilet (specify)			
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	· · · · · ·		
(3) Increase (decrease) in unearned premium reserve	•		
(4) Earned ((1) + (2) - (3))		9a(4)
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b((3)
(4) Claims charged		9b((4)
c Remainder of premium: (1) Retention charges (on an accrual basis) -	-		
(A) Commissions			
(B) Administrative service or other fees			
(C) Other specific acquisition costs			
(D) Other expenses			
(E) Taxes	2 (1)(=)		
(F) Charges for risks or other contingencies			
(G) Other retention charges		0-/4	VIII
(H) Total retention	_		
(2) Dividends or retroactive rate refunds. (These amounts were page 1.			
d Status of policyholder reserves at end of year: (1) Amount held to pro			
(2) Claim reserves			
(3) Other reserves			
Dividends or retroactive rate refunds due. (Do not include amount en	tered in c(2) .)	90)
10 Nonexperience-rated contracts:		10	7186
 Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs 			a 7100
b If the carrier, service, or other organization incurred any specific costs retention of the contract or policy, other than reported in Part I, item 2			b
Specify nature of costs			
,			
Part IV Provision of Information			

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

Schedule A (Form 5500) 2009

Part III

Welfare Benefit Contract Information

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			pursuant to Ef	e required to provide t RISA section 103(a)(2)				m is Open to Public Inspection	
For calendar plan year 20	09 or fiscal plar	year beginning	01/01/2009		and e	nding 12	/31/2009	_	
A Name of plan STOCK YARDS BANK AND TRUST COMPANY WELFARE P			PLAN			e-digit number (Pl	N) •	504	
	C Plan sponsor's name as shown on line 2a of Form 5500. STOCK YARDS BANK AND TRUST COMPANY				D Employer Identification Number (EIN) 61-0354170				
	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		CE							
(I.) FINI	(c) NAIC	(d) Contr	act or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification		persons covered a policy or contrac		(f)	From	(g) To	
59-0781901	60534	98991		8	38	01/01/20	009	12/31/2009	
2 Insurance fee and com descending order of the		ation. Enter the total	I fees and tota	I commissions paid. L	ist in item 3	3 the agents	, brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid									
	5570								
3 Persons receiving com	missions and fe	ees. (Complete as	many entries a	as needed to report all	persons).				
				or other person to who		sions or fees	were paid		
GREEN AND ASSOCIAT			521 BA	ARRETT AVE VILLE, KY 40204					
(b) Amount of sales ar	nd base		Fees	and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code		
5159								3	
	(a) Name a	nd address of the a	gent, broker, c	or other person to who	m commiss	sions or fees	were paid		
DRURY & COMPANY IN	DRURY & COMPANY INC PO BOX 869 FRANKLIN, TN 37065-0869								
(b) Amount of sales ar	nd hasa		Fees	and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose		pose (e) Orga		(e) Organization code	
	411							3	
For Paperwork Reduction	n Act Notice a	nd OMB Control N	lumbers, see	the instructions for F	orm 5500	_	Sch	 	

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 pen	-
(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Schedule A (Form 5500) 2009		Page 4	
Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts of the same group of such individual contracts of such individual contracts of such ind	roup of employees of the samurposes if such contracts are	experience-rated as a unit. Where contra	
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	b Dental	c Vision	d Life insurance
emporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug

а	X Health (other than dental or vision)	b Dental	с	Vision	d	Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemployme	ent h	Prescription drug
i	Stop loss (large deductible)	j HMO contract	k∏	PPO contract	ıŤ	Indemnity contract
m	吕 、	,	[• [_ macminy contract
) Ex	perience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))	<u></u>		9a	(4)	
k	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)	
C	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		9c(1)(E)			
	(F) Charges for risks or other contingencies	<u> </u>	9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention		<u></u>	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were paid in o	ash, or	redited.) 9c	(2)	
C	Status of policyholder reserves at end of year: (I) Amount held to provide be	enefits after	retirement9d	(1)	
	(2) Claim reserves			9d	(2)	
	(3) Other reserves			9d	(3)	
e	Dividends or retroactive rate refunds due. (Do r	ot include amount entered i	n c(2) .)	9	e	
1 0	Nonexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier		10	0a	30736
k	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				0b	

Part IV	Provision of Information			
11 Did th	e 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

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		re required to provide t RISA section 103(a)(2)	S(a)(2). Inspection				
For calendar plan year 20	09 or fiscal plar	n year beginning	01/01/2009		and e	nding 12	2/31/2009		
A Name of plan STOCK YARDS BANK AND TRUST COMPANY WELFARE PLAN			E PLAN			e-digit number (Pl	N) •	504	
	C Plan sponsor's name as shown on line 2a of Form 5500. STOCK YARDS BANK AND TRUST COMPANY				D Employer Identification Number (EIN) 61-0354170				
	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		CE							
(I.) FIN	(c) NAIC	(d) Conti	ract or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification		persons covered a policy or contract		(f)	From	(g) To	
59-0781901	60534	99001		4	42	01/01/20	009	12/31/2009	
2 Insurance fee and com descending order of the		ation. Enter the tota	I fees and total	I commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in	
(a) Total a	amount of com	missions paid			(b) To	otal amount	of fees paid		
	2554								
3 Persons receiving com	missions and fe	ees. (Complete as	many entries a	as needed to report all	persons).				
				or other person to who		ions or fees	were paid		
GREEN & ASSOCIATES				ARRETT AVE VILLE, KY 40204					
(b) Amount of sales ar	nd base		Fees	and other commission	ns paid				
commissions pa		(c) Amoun	t	(d) Purpose			(e) Organization code		
	2374								
	(a) Name a	nd address of the a	agent, broker, c	or other person to who	m commiss	ions or fees	were paid		
DRURY & COMPANY IN	C		PO BO FRANK	0X 869 KLIN, TN 37065-0869					
(b) Amount of sales ar	nd base		Fees	and other commission	ns paid				
commissions pa		(c) Amoun		(d) Purpose				(e) Organization code	
	180								
For Paperwork Reduction	n Act Notice a	nd OMB Control N	Jumbers, see	the instructions for F	orm 5500		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 pen	-
(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4	
	,

Pā	art II	If more than one contract covers the same g		same employ	ver(s) or members of th	e same em	plovee organization(s)	the
		information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experien	ce-rated as a unit. Who	ere contrac	ts cover individual empl	oyees,
8	Ben	efit and contract type (check all applicable boxes)	·					
	а	¬ '' '	b Dental	сГ	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription drug	
	i	Stop loss (large deductible)	i HMO contract	k	PPO contract		I Indemnity contract	ct
	m	Other (specify)	<i>,</i> –	L	_			
	L							
9	Ехре	erience-rated contracts:						
	a	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)				
		(3) Increase (decrease) in unearned premium res	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 (c	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies.						
		(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.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in c(2) .)		9e		
10	No	nexperience-rated contracts:						
	a	Total premiums or subscription charges paid to o				10a		14056
	b	If the carrier, service, or other organization incur			•	106		
	0	retention of the contract or policy, other than rep	orted in Part I, Item 2 abov	ve, report am	iount	. 10b		
	>p	pecify 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.

Insurance companies are required to provide the information

OMB No. 1210-0110

nurrought to FDICA continu 402/o\/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						
A Name of plan STOCK YARDS BANK AI	A Name of plan STOCK YARDS BANK AND TRUST COMPANY WELFARE PLAN			Three-digit plan number (Pl	N) •	504
	C Plan sponsor's name as shown on line 2a of Form 5500. STOCK YARDS BANK AND TRUST COMPANY D Employer Identification Number (EIN) 61-0354170 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract					EIN)
		ning Insurance Contractor Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance car HUMANA	rrier					
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end policy or contract yea	/+\	From	(g) To
39-1263473	73288	707486	333	01/01/20	009	12/31/2009
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. List in	item 3 the agents	, brokers, and c	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		39459				137177
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all perso	ons).		
	(a) Name	and address of the agent, broke	er, or other person to whom co	mmissions or fees	were paid	
AIS BENEFIT CONCEPT	SLLC		01 MAGISTERIAL DRIVE JISVILLE, KY 40223			
(b) Amount of sales ar	nd hase	F	ees and other commissions pa	nid		
commissions pai		(c) Amount	(d) Purpose			(e) Organization code
	39459	137177	ADMINISTRATIVE FEES			3
	(a) Name	and address of the agent, broke	er or other person to whom co	mmissions or fees	were naid	
(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						
commissions pai	d	(c) Amount	(d) P	urpose		(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 pen	-		
(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		
	<u> </u>	·

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10b

Schedu	ule A (Form 5500) 2009		F	Page 4		
If moi	fare Benefit Contract Informa e than one contract covers the same g nation may be combined for reporting p ntire group of such individual contracts	roup of employees of the sourposes if such contracts	are experien	ce-rated as a unit. Who	ere contract	
8 Benefit and co	ntract type (check all applicable boxes)				
a X Health	other than dental or vision)	b Dental	С	Vision		d Life insurance
e Tempoi	ary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment	h Prescription drug
i Stop los	ss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	specify) •	, 📋	_			
	specify)					
9 Experience-rat	ed contracts:					
•	(1) Amount received		9a(1)			
(2) Increa	se (decrease) in amount due but unpai	d				
(3) Increa	se (decrease) in unearned premium re	serve	9a(3)			
(4) Earne	d ((1) + (2) - (3))				9a(4)	
b Benefit cl	narges (1) Claims paid		9b(1)			
(2) Increa	se (decrease) in claim reserves		9b(2)			
` '	ed claims (add (1) and (2))				9b(3)	
(4) Claims	s charged				9b(4)	
	er of premium: (1) Retention charges (,		T		
(A) C	ommissions		9c(1)(A)			
(B) A	dministrative service or other fees		9c(1)(B)			
(C) O	ther specific acquisition costs		9c(1)(C)			
` '	ther expenses		9c(1)(D)			_
` '	axes		9c(1)(E)			_
	narges for risks or other contingencies		9c(1)(F)			_
(G) C	ther retention charges		9c(1)(G)			
` '	otal retention	_			9c(1)(H)	
(2) Divide	ends or retroactive rate refunds. (These	e amounts were 📗 paid ir	cash, or	credited.)	9c(2)	
d Status of	policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)	
(2) Claim	reserves				9d(2)	
` '	reserves				9d(3)	
e Dividend	s or retroactive rate refunds due. (Do r	not include amount entered	d in c(2) .)		9e	

Specify nature of costs	•
-------------------------	---

10 Nonexperience-rated contracts:

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

a Total premiums or subscription charges paid to carrier.....

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

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

¹² If the answer to line 11 is "Yes," specify the information 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

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				n is Open to Public Inspection			
For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/2009	9	and en	ding 12	/31/2009	
A Name of plan	•	OMPANY WELFARE PLAN		B Three			504
	C Plan sponsor's name as shown on line 2a of Form 5500. STOCK YARDS BANK AND TRUST COMPANY D Employer Identif 61-0354170					ation Number (EIN)
	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	rrier	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
74-2552026	60984	707486	17		01/01/20	09	12/31/2009
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of con	nmissions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie		nersons)			0
• 1 crooms receiving com		and address of the agent, broke			ons or fees	were naid	
REISERT INSURANCE	(2)	122	5 BARDSTOWN RD UISVILLE, KY 40204		<u> </u>	were paire	
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose		(e) Organization code		
1838							
	(a) Name	and address of the agent, broke	er, or other person to whor	n commissi	ons or fees	were paid	
(b) Amount of sales ar			ees and other commission				() 6
commissions pa	ıd	(c) Amount		(d) Purpose	!		(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 pen	-		
(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 c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	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			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4	

9d(2)

9d(3)

9e

10a

10b

17635

	Schedule A (Form 5500) 2009		F	Page 4				
Part III	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 contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
8 Bene	fit and contract type (check all applicable boxes)						
а	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance		
e	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	plovment	h Prescription drug		
ì Þ	Stop loss (large deductible)	j HMO contract	າ s_ k[PPO contract	,	I Indemnity contract		
 	Other (specify)	, Time contract				I I indemnity contract		
m _	Other (specify)							
9 Expe	rience-rated contracts:							
•	Premiums: (1) Amount received		9a(1)			-		
	(2) Increase (decrease) in amount due but unpai							
	(3) Increase (decrease) in unearned premium re					1		
	(4) Earned ((1) + (2) - (3))				. 9a(4)			
	Benefit charges (1) Claims paid							
	(2) Increase (decrease) in claim reserves							
	(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		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	e amounts were paid in	cash, or	credited.)	9c(2)			
d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement				

(2) Claim reserves.....

(3) Other reserves

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

a Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

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

10 Nonexperience-rated contracts:

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

Service Provider Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation		1	Inspection.
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009	and ending 12/31/	/2009	
A Name of plan	B Three-digit		
STOCK YARDS BANK AND TRUST COMPANY WELFARE PLAN	plan number (PN)	•	504
Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification	on Number	(EIN)
STOCK YARDS BANK AND TRUST COMPANY	61-0354170		
Part I Service Provider Information (see instructions)			
You must complete this Part, in accordance with the instructions, to report the information recorder or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which the answer line 1 but are not required to include that person when completing the remainder of the	with services rendered to he plan received the requ	the plan or	the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compensation	n		
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this		ved only eli	gible
indirect compensation for which the plan received the required disclosures (see instructions for	•		
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see instr	•	or the servic	e providers who
(b) Enter name and EIN or address of person who provided you disc	osures on eligible indirect	t compensa	tion
ADMINISTRATIVE INFORMATION MGMT INC 10353 LINN STATION RD LOUISVILLE, KY 40223			
61-1154715			
(b) Enter name and EIN or address of person who provided you disc	losure on eligible indirect	compensat	ion
(b) Enter name and EIN or address of person who provided you disc	osures on eligible indirect	compensa	tion
(b) Enter name and EIN or address of person who provided you disc	osures on eligible indirect	compensa	tion
·			

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

answered	l "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in to	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
			- ,			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page 4- 1	Page	4-	1
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(a) Enter name and EIN or address (see instructions)							
(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service	
Code(s)	employer, employee	compensation paid by the plan. If none, enter -0	receive indirect compensation? (sources other than plan or plan	include eligible indirect compensation, for which the plan received the required	compensation received by service provider excluding eligible indirect	provider give you a formula instead of an amount or	
	a party-in-interest		sponsor)	disclosures?		estimated amount?	
			Yes No No	Yes No		Yes No	
		(a) Enter name and EIN or	address (see instructions)			
(b)	(c)	(d)	(e)	(f)	_ (g)	(h)	
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a	
	person known to be	by the plan. If none, enter -0	other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or	
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element (f). If none, enter -0	estimated amount?	
			Yes No	Yes ☐ No ☐		Yes No	
						100 [] 110 []	
		(a) Enter name and EIN or	address (see instructions)			
(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a	
	person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or	
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element (f). If none, enter -0	estimated amount?	
			Yes No	Yes No		Yes No No	

Schedule	C	Form	5500)	2009
Ochicadic	\sim		3300	, 2000

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Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

many entiries as needed to report the required information for each source.		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(a) Describe the indirect	compensation, including any
(a) Enter name and Env (address) of source of maneer compensation	formula used to determine	the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

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Part II Service Providers Who Fail or Refuse to Provide Information						
4 Provide, to the extent possible, the following information for earthis Schedule.	Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
а	Name:	b EIN:		
С	Position:			
d	Address:	e Telephone:		
Ex	xplanation:			
а	Name:	b EIN:		
C	Position:			
d	Address:	e Telephone:		
Ex	xplanation:			
а	Name:	b EIN:		
C	Position:	D LIN.		
d	Address:	e Telephone:		
Ex	xplanation:			
а	Name:	b EIN;		
C	Position:	D Enti		
d	Address:	e Telephone:		
-				
Ex	xplanation:			
а	Name:	b EIN;		
C	Position:			
d	Address:	e Telephone:		
Ex	xplanation:			

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Department of Labor

Financial Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2009

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			B Three-digit			
STOCK YARDS BANK AND TRUST COMPANY WELFARE PLAN		plan number (P	N) •	504		
C Plan sponsor's name as shown on line 2a of Form 5500			D Employer Identifi	cation Number (E	IN)	
STOCK YARDS BANK AND TRUST COMPANY			04.0054470			
			61-0354170			
Part I Asset and Liability Statement						
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.						
Assets		(a) B	eginning of Year	(b) End	of Year	
a Total noninterest-bearing cash	1a					
b Receivables (less allowance for doubtful accounts):						
(1) Employer contributions	1b(1)					
(2) Participant contributions	1b(2)					
(3) Other	1b(3)					
C General investments:						
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)					
(2) U.S. Government securities	1c(2)					
(3) Corporate debt instruments (other than employer securities):						
(A) Preferred	1c(3)(A)					
(B) All other	1c(3)(B)					
(4) Corporate stocks (other than employer securities):						
(A) Preferred	1c(4)(A)					
(B) Common	1c(4)(B)					
(5) Partnership/joint venture interests	1c(5)					
(6) Real estate (other than employer real property)	1c(6)					
(7) Loans (other than to participants)	1c(7)					
(8) Participant loans	1c(8)					
(9) Value of interest in common/collective trusts	1c(9)					
(10) Value of interest in pooled separate accounts	1c(10)				·	
(11) Value of interest in master trust investment accounts	1c(11)					
(12) Value of interest in 103-12 investment entities	1c(12)					
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)					

1c(14)

1c(15)

(14) Value of funds held in insurance company general account (unallocated

contracts).....

	Schedule H (Form 5500) 2009	Pag	ge 2	
1d Er	mployer-related investments:		(a) Beginning of Year	(b) End of Year
(1)) Employer securities	1d(1)	., .	, ,
(2	Employer real property	1d(2)		
e Bu	uildings and other property used in plan operation	1e		
f To	otal assets (add all amounts in lines 1a through 1e)	1f		
	Liabilities			
g Be	enefit claims payable	1g		
h o	perating payables	1h		
i Ad	cquisition indebtedness	1i		
j Ot	ther liabilities	1j		
k To	otal liabilities (add all amounts in lines 1g through1j)	1k		
	Net Assets	·		
I Ne	et assets (subtract line 1k from line 1f)	11		
fun	II Income and Expense Statement n income, expenses, and changes in net assets for the year. Include all incod(s) and any payments/receipts to/from insurance carriers. Round off amour as 2a, 2b(1)(E), 2e, 2f, and 2g.			
	Income		(a) Amount	(b) Total
a co	ontributions:		, ,	, ,
(1)) Received or receivable in cash from: (A) Employers	2a(1)(A)		
	(B) Participants	2a(1)(B)		-
	(C) Others (including rollovers)	2a(1)(C)		-
(2)) Noncash contributions	2a(2)		-
(3)	Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		
_	arnings on investments:			
(1)	Interest: (A) Interest-bearing cash (including money market accounts and cartificates of denosit)	2b(1)(A)		

2b(1)(B)

2b(1)(C)

2b(1)(D)

2b(1)(E)

2b(1)(F)

2b(1)(G)

2b(2)(A)

2b(2)(B)

2b(2)(C)

2b(2)(D) 2b(3)

2b(4)(A)

2b(4)(B)

2b(4)(C)

certificates of deposit).....

(B) U.S. Government securities.....

(D) Loans (other than to participants)

(E) Participant loans

(F) Other.....

(G) Total interest. Add lines 2b(1)(A) through (F).....

(C) Registered investment company shares (e.g. mutual funds).....

(3) Rents.....

(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds

(B) Aggregate carrying amount (see instructions)

(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....

(C) Corporate debt instruments

(2) Dividends: (A) Preferred stock.....

(D) Total dividends. Add lines 2b(2)(A), (B), and (C)

(B) Common stock.....

Pac	ıe	3

			(a) Amount	(b) Total
2b	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		
	(6) Net investment gain (loss) from common/collective trusts	2b(6)		
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
((10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
С	Other income	2c		
d	Total income. Add all income amounts in column (b) and enter total	2d		
	Expenses			
е	Benefit payment and payments to provide benefits:			
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
	(2) To insurance carriers for the provision of benefits	2e(2)		
	(3) Other	2e(3)		
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		
f	Corrective distributions (see instructions)	2f		
	Certain deemed distributions of participant loans (see instructions)	2g		
	Interest expense	2h		
i	Administrative expenses: (1) Professional fees	2i(1)		
	(2) Contract administrator fees	2i(2)		
	(3) Investment advisory and management fees	2i(3)		
	(4) Other	2i(4)		
	(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		
	, , , , , ,	2j		
J	Total expenses. Add all expense amounts in column (b) and enter total Net Income and Reconciliation	-,		<u> </u>
l.	Ī	2k		
ĸ	Net income (loss). Subtract line 2j from line 2d	ZR		
•	Transfers of assets:	21/4)		
	(1) To this plan	2l(1)		
	(2) From this plan	21(2)		
Pa	art III Accountant's Opinion			
	Complete lines 3a through 3c if the opinion of an independent qualified public adattached.	ccountant is	attached to this Form 5500. Com	plete line 3d if an opinion is not
а	The attached opinion of an independent qualified public accountant for this plan	is (see insti	ructions):	
	(1) Unqualified (2) Qualified (3) Disclaimer (4)	Adverse		
b [Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-	8 and/or 10	3-12(d)?	Yes No
C	Enter the name and EIN of the accountant (or accounting firm) below:			
	(1) Name:		(2) EIN:	
d T	The opinion of an independent qualified public accountant is not attached beca			
	(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attach	ned to the ne	ext Form 5500 pursuant to 29 CFF	₹ 2520.104-50.

Pa	rt IV Compliance Questions					
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.	e, 4f, 4g,	4h, 4k, 4	m, 4n, or 5	j.	
	During the plan year:		Yes	No	Amo	unt
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X		
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X		
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X		
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X		
е	Was this plan covered by a fidelity bond?	4e		X		
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			X		
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X		
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	79		V		
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked	·		X		
j	and see instructions for format requirements.)	4i		X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j r 4k		X		
ı	Has the plan failed to provide any benefit when due under the plan?	41		X		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			X		
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			X		
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year	Yes	X No	Amour	nt:	
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(transferred. (See instructions.)	s), identi	fy the pla	n(s) to wh	ich assets or liabi	lities were
	5b(1) Name of plan(s)			5b(2) EIN	(s)	5b(3) PN(s)
	-					1