Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089		
Department of the Treasury Internal Revenue Service	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).	2009		
Department of Labor Employee Benefits Security Administration	<ul> <li>Complete all entries in accordance with the instructions to the Form 5500.</li> </ul>	2009		
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection		
Part I Annual Report Ide	ntification Information			
For calendar plan year 2009 or fisca	plan year beginning 03/01/2009 and ending 02/28/2	2010		
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or			
	a single-employer plan;			
<b>B</b> This return/report is:	the first return/report; the final return/report;			
	an amended return/report; a short plan year return/report (less the second seco	han 12 months).		
<b>C</b> If the plan is a collectively bargain	ned plan, check here.	_		
<b>D</b> Check box if filing under:	Form 5558; automatic extension;	the DFVC program;		
	special extension (enter description)			
Part II Basic Plan Infor	mation—enter all requested information			
<b>1a</b> Name of plan SAVER GROUP, INC. WELFARE B	ENEFIT PROGRAM	1b Three-digit plan number (PN) ► 501		
		<b>1c</b> Effective date of plan 03/01/1992		
2a Plan sponsor's name and addre (Address should include room or SAVER GROUP, INC.	ss (employer, if for a single-employer plan) suite no.)	<b>2b</b> Employer Identification Number (EIN) 31-1532482		
		<b>2c</b> Sponsor's telephone number 270-465-8675		
95 LONDON DRIVE PO BOX 1058 CAMPBELLSVILLE, KY 42719	95 LONDON DRIVE PO BOX 1058 CAMPBELLSVILLE, KY 42719	2d Business code (see instructions) 445110		

## Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	12/15/2010	
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Page 2

	<b>a</b> Plan administrator's name and address (if same as plan sponsor, enter "Same") <b>3b</b> Administrator's Ell         AVER GROUP, INC.       31-1532482		
PC	LONDON DRIVE BOX 1058 MPBELLSVILLE, KY 42719	nu	ministrator's telephone mber )-465-8675
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:	and	4b EIN
а	Sponsor's name		<b>4c</b> pn
5	Total number of participants at the beginning of the plan year	5	485
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
а	Active participants	6a	551
b	Retired or separated participants receiving benefits	6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a, 6b, and 6c	6d	551
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>	6f	551
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

### **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A 4B 4D 4E 4F 4H

9a	Plan fun	ding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)			
	(1)	X Insurance	(1)	X Insurance		
	(2)	Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3) insurance contracts		
	(3)	Trust	(3)	Trust		
	(4)	General assets of the sponsor	(4)	General assets of the sponsor		
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number				ere indicated, enter the number attached. (See instructions)		
	a Pension Schedules					
а	Pensior	) Schedules	b General S	Schedules		
а	Pensior (1)	Schedules R (Retirement Plan Information)	b General S (1)	Chedules H (Financial Information)		
а						
а	(1)	R (Retirement Plan Information)         MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(1)	H (Financial Information)		
а	(1)	R (Retirement Plan Information)           MB (Multiemployer Defined Benefit Plan and Certain Money)	(1) (2)	<ul> <li>H (Financial Information)</li> <li>I (Financial Information – Small Plan)</li> </ul>		
а	(1)	R (Retirement Plan Information)         MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(1) (2) (3)	H (Financial Information) I (Financial Information – Small Plan) <u>7</u> A (Insurance Information)		

						1	
SCHEDULE	E A	Insuranc	ce Information	n		ОМ	B No. 1210-0110
•	(Form 5500) Department of the Treasury This schedule is required to be filed under section 104 of the						
Department of the Trea Internal Revenue Ser	vice	Employee Retirement Inc					2009
Department of Labo Employee Benefits Security A		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty C	orporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	009 or fiscal plan	year beginning 03/01/2009		and e	nding 02	2/28/2010	•
A Name of plan SAVER GROUP, INC. W	/ELFARE BENE	FIT PROGRAM			e-digit number (P	N) 🕨	501
C Plan sponsor's name a SAVER GROUP, INC.	as shown on line	2a of Form 5500.		<b>D</b> Emplo 31-153	•	cation Number (	(EIN)
		ing Insurance Contract ( Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
UNITED OF OMAHA LIF		COMPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		Policy or cor		ontract year
	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
47-0322111	69868	GLUG0501G	55	551 01/01/2009		009	01/01/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
<b>(a)</b> Total	amount of comm			<b>(b)</b> To	otal amount	of fees paid	
		5028					
3 Persons receiving con		es. (Complete as many entries	I	. /			
BB & T INSURANCE SE		nd address of the agent, broker,	or other person to who X 436869	m commiss	ions or fees	s were paid	
	ittilee, iitte.	LÕŪĪŠ	3VILLE, KY 40253				
(b) Amount of sales a			s and other commission				
commissions pa		(c) Amount	(c) Amount (d) Purpose		se		(e) Organization code
	5028						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
	and base	Fee	s and other commission	ns paid			
(b) Amount of sales a commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500
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#### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

<b>(b)</b> Amount of sales and base commissions paid	Fees and other commissions paid			
	(c) Amount	(d) Purpose	(e) Organization 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		(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		(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			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			<b>6d</b>	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )				
	<b>e</b> [	Deductions:				
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	(	(4) Other (specify below)	. 7e(4)			
		▶				
	(	(5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f	

201

		Schedule A (Form 5500) 2009			I	Page <b>4</b>			
Part	: 11	Welfare Benefit Contract Informati If more than one contract covers the same group information may be combined for reporting put the entire group of such individual contracts w	up of employ poses if such	contracts a	re experier	ice-rated as a u	nit. Where contra		
<b>8</b> B	ene	fit and contract type (check all applicable boxes)							
а	ıГ	Health (other than dental or vision)	<b>b</b> Dental		с	Vision		d 🗙	Life insurance
е	Γ	Temporary disability (accident and sickness)	f Long-te	erm disability	⁄ g	Supplementa	al unemployment	h∏	Prescription drug
i		Stop loss (large deductible)	j HMO co		k	PPO contrac			Indemnity contract
				Jillaol	κ.		, c	•	Indemnity contract
n	<u>ו</u>	Other (specify)							
9 E>	ne	rience-rated contracts:							
	•	remiums: (1) Amount received		Г	9a(1)			_	
		2) Increase (decrease) in amount due but unpaid		-	9a(2)				
		<ul> <li>3) Increase (decrease) in unearned premium rese</li> </ul>			9a(3)				
		(4) Earned ((1) + (2) - (3))			. /				
k		Benefit charges (1) Claims paid					9000	0	
		2) Increase (decrease) in claim reserves			9b(2)				
		(3) Incurred claims (add (1) and (2))							90000
		(4) Claims charged							
C	;	Remainder of premium: (1) Retention charges (on	an accrual b	asis)					
		(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	I)	
		(2) Dividends or retroactive rate refunds. (These	amounts were	e paid in	cash, or	credited.)	9c(2)		
C	k	Status of policyholder reserves at end of year: (1)	Amount held	to provide b	enefits afte	r retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
e		Dividends or retroactive rate refunds due. (Do no	t include amo	unt entered	in <b>c(2)</b> .)				
10	No	experience-rated contracts:							
â		Total premiums or subscription charges paid to ca							27718
k	C	If the carrier, service, or other organization incurre	ed any specific	c costs in co	nnection w	ith the acquisition	on or		

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

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

10b

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs 🕨

SCHEDULE	A	Insuran	ce Informatio	n			D.N. 4040.0440
(Form 5500	))					OM	B No. 1210-0110
	Department of the Treasury Internal Revenue Service This schedule is required to be filed under section Employee Retirement Income Security Act of 197						
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	Insurance companies pursuant to l	are required to provide t ERISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 03/01/2009	( ),( )	and e	nding 02	2/28/2010	Inspection
A Name of plan				B Thre	e-digit		504
SAVER GROUP, INC. W	ELFARE BENE	FIT PROGRAM		plan	number (P	N)	501
C Plan sponsor's name a SAVER GROUP, INC.	as shown on line	e 2a of Form 5500.		<b>D</b> Emplo 31-153	-	cation Number (	EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:		individual contracto grouped as					/
0							
(a) Name of insurance ca							
ANTHEM HEALTH PLAN	IS OF KY D.B.A	A. ANTHEM BLUE CROSS AND	BLUE SHIELD				
	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or co	ontract year
(b) EIN	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
61-1237516 95120		00092132	705		03/01/20	009	02/28/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	al commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
<b>(a)</b> Total a	amount of comr			<b>(b)</b> To	otal amount	of fees paid	
		57247					
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	. ,	nd address of the agent, broker,		m commiss	ions or fees	s were paid	
BB & T INSURANCE SEI	RVICES, INC.		OX 436869 SVILLE, KY 40253				
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
57247							3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
	(1) 1 10110 0						
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount (d) Purpose			(e) Organization code		

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

Schedule A (Form 5500) 2009 v.092308.1

#### (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 paid	(c) Amount	(d) Purpose	(e) Organization 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		(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				
commissions paid	(c) Amount	(d) Purpose	(e) Organization 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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			<b>6d</b>	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )				
	<b>e</b> [	Deductions:				
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	(	(4) Other (specify below)	. 7e(4)			
		▶				
	(	(5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f	

Page	4
raye	-

Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts of	oup of employees o urposes if such cont	racts are experienc	ce-rated as a unit. Where	contracts	
8	Ben	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	<b>b</b> Dental	с	Vision	c	Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term di	isability <b>g</b>	Supplemental unemploy	ment <b>h</b>	Prescription drug
	: F	Stop loss (large deductible)	j HMO contrac		PPO contract		
						I	Indemnity contract
	m	Other (specify)					
9	Expe	erience-rated contracts:					
	а	Premiums: (1) Amount received			1	893438	
		(2) Increase (decrease) in amount due but unpaid	۶				
		(3) Increase (decrease) in unearned premium res	erve				
		(4) Earned ((1) + (2) - (3))				9a(4)	1893438
	b	Benefit charges (1) Claims paid			1	489277	
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	1489277
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions				57247	
		(B) Administrative service or other fees				216753	
		(C) Other specific acquisition costs					
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				:(1)(H)	274000
		(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 not	ot include amount e	ntered in <b>c(2)</b> .)		9e	
10	) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c				10a	
	b	If the carrier, service, or other organization incurr				106	
		retention of the contract or policy, other than reported in Part I, item 2 above, report amount				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	× No	

SCHEDULE A Insurance Information			OMB No. 1210-0110				
(Form 550 Department of the Tree Internal Revenue Se	f the Treasury This schedule is required to be filed under section 104 of the				2000		
Department of Lal	oor	Employee Retirement Inc	ttachment to Form 55		).		2009
Employee Benefits Security / Pension Benefit Guaranty		Insurance companies a		he informat	ion	This Fo	rm is Open to Public
For calendar plan year 2	009 or fiscal plan	•		and e	nding 02	2/28/2010	Inspection
Name of plan SAVER GROUP, INC. \	VELFARE BENE	FIT PROGRAM			e-digit number (Pl	N) 🕨	501
Plan sponsor's name SAVER GROUP, INC.				31-153	32482	cation Number	
		ing Insurance Contract ( Individual contracts grouped as a					
Coverage Information	:						
a) Name of insurance of the GUARDIAN LIFE I		MPANY OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
3-5123390	64246	00422505	20	05	03/01/20	009	02/28/2010
		tion. Enter the total fees and tota	al commissions paid. Li	ist in item 3	the agents	, brokers, and	other persons in
descending order of th (a) Tota	l amount of com	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		6762					334
Persons receiving co		ees. (Complete as many entries		. ,			
3B & T INSURANCE SI			or other person to whor OX 436869 SVILLE, KY 40253	m commiss	ions or fees	s were paid	
(b) Amount of sales	and base	Fee	s and other commission	ns paid			
commissions p		(c) Amount	(d) Purpose			(e) Organization code	
	6753	3341 BC	ONUS COMPENSATIO	N			3
			or other person to who	m commiss	ions or fees	s were paid	-
	(a) Name a	nd address of the adent. broker					
LIFETIME FIN GROWT	. <i>i</i>		LVD OF THE ALLIES BURGH, PA 15222				
LIFETIME FIN GROWT		LC 244 B PITTS	LVD OF THE ALLIES	ns paid			
IFETIME FIN GROWT (b) Amount of sales commissions p	H CO OF OHIO I	LC 244 B PITTS	LVD OF THE ALLIES BURGH, PA 15222 s and other commission	ns paid <b>(d)</b> Purpos	e		(e) Organization 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				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid			

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	

(a) Name and 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 paid	(c) Amount	(d) Purpose	(e) Organization 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		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			<b>6d</b>	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )				
	<b>e</b> [	Deductions:				
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	(	(4) Other (specify below)	. 7e(4)			
		▶				
	(	(5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f	

Page **4** 

Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	oup of employees o Irposes if such con	tracts are experier	ice-rated as a u	nit. Where contra		
8	Ben	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> X Dental	c	Vision		d 🗌 Life insuran	се
	еĪ	Temporary disability (accident and sickness)	f Long-term d	lisability <b>g</b>	 	al unemployment	<b>h</b> Prescription	n drug
	; [	Stop loss (large deductible)	i HMO contra					-
	. L			ιcι <b>κ</b> [		-t	I Indemnity co	ontract
	m	Other (specify)						
0	-	erience-rated contracts:						
9		Premiums: (1) Amount received					-	
	a	(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium res						
		(4) Earned ((1) + (2) - (3))						
	b	Benefit charges (1) Claims paid				•••(1)		
		(2) Increase (decrease) in claim reserves					-	
		(3) Incurred claims (add (1) and (2))						
		(4) Claims charged						
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs						
		(D) Other expenses						
		(E) Taxes						
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		•				
		(H) Total retention	_				<u>)</u>	
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	credited.)			
	d	Status of policyholder reserves at end of year: (1	, I					
		(2) Claim reserves						
		(3) Other reserves						
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount e	entered in <b>c(2)</b> .)				
10	-	nexperience-rated contracts:						67504
	a ⊾	Total premiums or subscription charges paid to c						67534
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo						
		recontion of the contract of policy, other than rept		z above, report an			1	

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	× No	
40				

	1					T	
SCHEDULE	A	Insurance	ce Informatio	n		OM	IB No. 1210-0110
(Form 5500)							
Department of the Treasury Internal Revenue Service This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2009		
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	are required to provide t RISA section 103(a)(2)		lion		m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 03/01/2009		and e	nding 02	2/28/2010	
A Name of plan SAVER GROUP, INC. W	ELFARE BENE	FIT PROGRAM			e-digit number (P	N) 🕨	501
C Plan sponsor's name a SAVER GROUP, INC.	as shown on line	2a of Form 5500.		<b>D</b> Emplo 31-153	•	cation Number	(EIN)
		ing Insurance Contract ( Individual contracts grouped as a					
<b>1</b> Coverage Information:							
(a) Name of insurance ca	vrior						
UNITED OF OMAHA LIF		COMPANY					
	(c) NAIC	AIC (d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	<b>(g)</b> To
47-0322111	69868	GVTL0501G	1;	32	03/01/20	009	02/28/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
(a) Total	amount of comn		(b) Total amount of fees paid				
		5701					
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	. ,	nd address of the agent, broker,		m commiss	ions or fees	s were paid	
BB & T INSURANCE SEI	RVICES, INC.		OX 436869 SVILLE, KY 40253				
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
5701							3
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of color	nd bass	Fee	s and other commission	ns paid			
(b) Amount of sales and base commissions paid		(c) Amount	(d) Purpose			(e) Organization code	

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

#### (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 paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	5			
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			<b>6d</b>	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )				
	<b>e</b> [	Deductions:				
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	(	(4) Other (specify below)	. 7e(4)			
		▶				
	(	(5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f	

		Schedule A (Form 5500) 2009			Р	age <b>4</b>			
Par	't III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts	oup c urpos	es if such contracts a	are experiend	ce-rated as a unit. Wh	ere contract		
<b>8</b> E	Bene	afit and contract type (check all applicable boxes)							
i	a	Health (other than dental or vision)	b	Dental	с	Vision		d 🛛 Life insuran	се
	еГ	Temporary disability (accident and sickness)	f	Long-term disabilit	y g	Supplemental unem	plovment	<b>h</b> Prescription	drua
i	ιΓ	Stop loss (large deductible)	iΓ	HMO contract	, s∟ k	PPO contract		I Indemnity co	•
	' L ~ [\	Other (specify) $\blacktriangleright$ AD & D	<u>ا</u> د		· _				Jillaol
	n >	Other (spechy)							
<b>9</b> E	xpe	rience-rated contracts:							
	•	Premiums: (1) Amount received			9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid	dk					]	
		(3) Increase (decrease) in unearned premium res	erve.		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 (or	n an a	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					9c(2)		
	d	Status of policyholder reserves at end of year: (1	) Amo	ount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves					. 9d(2)		
		(3) Other reserves					. 9d(3)		
		Dividends or retroactive rate refunds due. (Do n	ot incl	lude amount entered	l in <b>c(2)</b> .)		9e		
10		nexperience-rated contracts:							
		Total premiums or subscription charges paid to c					. <b>10a</b>		30845
		If the carrier, service, or other organization incur					104		
		retention of the contract or policy, other than repe	buted	in Part I, Item 2 abov	ve, report am	ount	. <b>10b</b>		

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

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs 🕨

SCHEDULE A Insurance Information						OM	B No. 1210-0110
(Form 5500	,						
Department of the Treat Internal Revenue Serv		This schedule is required Employee Retirement Inc		2009			
Department of Labo Employee Benefits Security Ac		File as an at					
Pension Benefit Guaranty Co	orporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 03/01/2009		and e	nding 02	2/28/2010	
A Name of plan SAVER GROUP, INC. W	ELFARE BENE	FIT PROGRAM			e-digit number (P	N) 🕨	501
				_			
C Plan sponsor's name as shown on line 2a of Form 5500. SAVER GROUP, INC. D Employer Identification Number (E 31-1532482							EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:				•		0	
(a) Name of insurance ca UNITED OF OMAHA LIF		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				ontract year
(b) EIN	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
47-0322111	69868	GUC0501G	11	12	03/01/20	009	02/28/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
(a) Total	amount of comn			<b>(b)</b> To	otal amount	of fees paid	
		4130					
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, o	or other person to who X 436869	m commiss	ions or fees	s were paid	
BB & T INSURANCE SE	RVICES, INC.		SVILLE, KY 40253				
(b) Amount of sales a	nd base	Fee	s and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
4130							3
	(a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			
commissions pa	(d) Purpose			(e) Organization code			

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

#### (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 paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and 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 paid	(c) Amount	(d) Purpose	(e) Organization 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				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of		
		this report.			, 			
-		ent value of plan's interest under this contract in the general account at year of						
-		Current value of plan's interest under this contract in separate accounts at year end						
6		acts With Allocated Funds:						
	а	State the basis of premium rates						
	h				Ch			
		Premiums paid to carrier			6b 6c			
		Premiums due but unpaid at the end of the year						
		retention of the contract or policy, enter amount			<b>6d</b>			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here				
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •					
				ition guarantee				
		(3) ☐ guaranteed investment (4) ☐ other ►		C C				
	b	Balance at the end of the previous year						
		Additions: (1) Contributions deposited during the year						
		(2) Dividends and credits	= (0)					
		(3) Interest credited during the year						
		(4) Transferred from separate account						
		(5) Other (specify below)						
		(6)Total additions			7c(6)			
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )						
	<b>e</b> [	Deductions:						
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	. 7e(2)					
		(3) Transferred to separate account	. 7e(3)					
	(	(4) Other (specify below)	. 7e(4)					
		▶						
	(	(5) Total deductions						
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f			

Pa	art II						
		If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts of	urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contrac	
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance
	e 🖻	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unemp	olovment	<b>h</b> Prescription drug
	iΓ	Stop loss (large deductible)	i HMO contract	י ט_ k	PPO contract		I Indemnity contract
	- L			n_			
	m	Other (specify)					
9	Expe	rience-rated contracts:					
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	t	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)		22434	•
		(2) Increase (decrease) in claim reserves		. 9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	22434
		(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					
		(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				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)	
		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in <b>c(2)</b> .)		9e	
10		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to o				10a	21991
	b	If the carrier, service, or other organization incur				405	
		retention of the contract or policy, other than rep	orted in Part I, item 2 abo	ve, report am	ount	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	× No	

SCHEDULE	Α	Insuranc	ce Information	n		OM	B No. 1210-0110
(Form 5500	)					B NO. 1210-0110	
Department of the Treas Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2009		
Department of Labo Employee Benefits Security Ad		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 03/01/2009		and e	nding <mark>0</mark> 2	2/28/2010	
A Name of plan SAVER GROUP, INC. W	ELFARE BENE	FIT PROGRAM			e-digit number (P	N) 🕨	501
				<b>D</b> - 1			
C Plan sponsor's name a SAVER GROUP, INC.	as shown on line	2a of Form 5500.		<b>D</b> Emplo 31-153	•	cation Number (	EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:						0	
(a) Name of insurance ca UNITED OF OMAHA LIF		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
47-0322111 69868		GUPR0501G	70 03/01/20		009	02/28/2010	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
<b>(a)</b> Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		3335					
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, o		m commiss	ions or fees	s were paid	
BB & T INSURANCE SEI	RVICES, INC.		DX 436869 SVILLE, KY 40253				
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
3335							3
	(a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount				(e) Organization code	

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

#### (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 paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid		

( <b>b)</b> Amount of sales and base commissions paid		(e) Organization	
	(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			
commissions paid	(c) Amount	(d) Purpose	(e) Organization 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			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			<b>6d</b>	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )				
	<b>e</b> [	Deductions:				
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	(	(4) Other (specify below)	. 7e(4)			
		▶				
	(	(5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f	

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Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts	oup of employees of the s urposes if such contracts	are experienc	ce-rated as a unit. Whe	ere contract		s,
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance	
	еĪ	Temporary disability (accident and sickness)	f X Long-term disabilit	ty g	Supplemental unemp	oloyment	<b>h</b> Prescription drug	
	iΓ	Stop loss (large deductible)	i HMO contract	, S_ k	PPO contract	,	I Indemnity contract	
	- L	Other (specify)		•				
	m	Other (specify)						
9	Expe	rience-rated contracts:						
		Premiums: (1) Amount received		9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid	ł				1	
		(3) Increase (decrease) in unearned premium res					1	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)		3304		
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)	3	304
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies.						
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention	<u></u>	······ <u>-</u> ··		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	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 not	ot include amount entered	d in <b>c(2)</b> .)		9e		
10		nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a	17	854
	b	If the carrier, service, or other organization incurr				401		
		retention of the contract or policy, other than repo	orted in Part I, item 2 abov	ve, report am	ount	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	× No	

						-		
SCHEDULE	A	Insuran	ce Informatio	n			D.N 4040.0440	
(Form 5500	)					OM	B No. 1210-0110	
Department of the Treas Internal Revenue Serv		This schedule is require Employee Retirement In					2009	
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	00.				
Pension Benefit Guaranty Co	orporation	<ul> <li>Insurance companies are required to provide the information</li> </ul>			This For	m is Open to Public		
For colordor plan year 20		•	ERISA section 103(a)(2)		nding 00		Inspection	
For calendar plan year 2009 or fiscal plan year beginning       03/01/2009       and ending       02/28/2010         A Name of plan       B Three-digit			2/20/2010					
SAVER GROUP, INC. WELFARE BENEFIT PROGRAM				number (P	N)	501		
				plan		<u>, , , , , , , , , , , , , , , , , , , </u>		
C Plan sponsor's name a	as shown on line	2a of Form 5500.		<b>D</b> Emplo	over Identific	cation Number (	EIN)	
SAVER GROUP, INC.				31-153	-		, ,	
		ing Insurance Contract						
	e Schedule A.	Individual contracts grouped as	a unit in Parts II and III	can be rep	orted on a s	ingle Schedule	Α.	
1 Coverage Information:								
(a) Name of insurance ca	rrier							
ANTHEM HEALTH PLAN	IS OF KY D.B.A	ANTHEM BLUE CROSS AND	BLUE SHIELD					
(b) <b>(c)</b> NAIO		(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To	
61-1237516	6         95120         00013898         309         03/01/2009		02/28/2010					
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	tal commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in	
(a) Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid		
		1887						
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).				
		nd address of the agent, broker,	•	m commiss	ions or fees	s were paid		
BB & T INSURANCE SEI	RVICES, INC.		30X 436869 ISVILLE, KY 40253					
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid				
commissions pa	id	(c) Amount		(d) Purpos	e		(e) Organization code	
	1887						3	
	(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	ions or fees	s were paid		
			· · · ·			·		
(b) Amount of sales ar	ad base	Fee	es and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	

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

Schedule A (Form 5500) 2009 v.092308.1

#### (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 paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and 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 paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	(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 paid	(c) Amount	(d) Purpose	(e) Organization code	

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			<b>6d</b>	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )				
	<b>e</b> [	Deductions:				
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	(	(4) Other (specify below)	. 7e(4)			
		▶				
	(	(5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f	

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Pa	rt III	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr information may be combined for reporting pu						
		the entire group of such individual contracts						mpioyees,
8	Bene	fit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> Dental	с×	Vision		d Life insuranc	е
	e	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unemp	oloyment	<b>h</b> Prescription	drug
	iΓ	Stop loss (large deductible)	j HMO contract	k	PPO contract	-	I Indemnity co	otract
	m	Other (specify)	, []	L				
9	Expe	rience-rated contracts:						
	<b>a</b> P	remiums: (1) Amount received		9a(1)				
	(	2) Increase (decrease) in amount due but unpaid	۱	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		9b(1)				
	(	2) Increase (decrease) in claim reserves		9b(2)		_		
	(	3) Incurred claims (add (1) and (2))				9b(3)		
	(	4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies.						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n 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 <b>c(2)</b> .)		. 9e		
10	Nor	nexperience-rated contracts:				•		
	а	Total premiums or subscription charges paid to c	arrier			10a		19982
	b	If the carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
		retention of the contract or policy, other than repo				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	× No	

SCHEDULE C	(Form 5500) Department of the Treasury This schedule is required to be filed under section 104 of the Employee			DMB No. 1210-0110
. , ,				2009
Department of Labor Employee Benefits Security Administration	- ► File as an attachn -		This F	form is Open to Public
Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal p	lan year beginning 03/01/2009	and ending 02/2	3/2010	Inspection.
A Name of plan SAVER GROUP, INC. WELFARE BEN		B Three-digit plan number (PN)	•	501
C Plan sponsor's name as shown on I SAVER GROUP, INC.	ine 2a of Form 5500	D Employer Identificat 31-1532482	ion Number	(EIN)
Part I Service Provider Inf	ormation (see instructions)			
or more in total compensation (i.e., r plan during the plan year. If a perso answer line 1 but are not required to	ordance with the instructions, to report the is money or anything else of monetary value) on received <b>only</b> eligible indirect compensa o include that person when completing the r eceiving <b>Only Eligible Indirect Co</b>	in connection with services rendered to titon for which the plan received the req remainder of this Part.	the plan or	the person's position with the
<ul> <li>indirect compensation for which the</li> <li>b If you answered line 1a "Yes," enter received only eligible indirect compensation</li> </ul>	ther you are excluding a person from the replan received the required disclosures (see r the name and EIN or address of each per ensation. Complete as many entries as nee	e instructions for definitions and conditions on providing the required disclosures eded (see instructions).	for the servic	e providers who
(b) Enter na ANTHEM BLUE CROSS AND BLUE S	ame and EIN or address of person who pro SHIELD	wided you disclosures on eligible indire	ct compensa	tion
61-1237516				
(b) Enter na	ame and EIN or address of person who pro	ovided you disclosure on eligible indirec	t compensat	ion
(b) Enter na	ame and EIN or address of person who prov	vided you disclosures on eligible indire	ct compensa	tion
(b) Enter na	ame and EIN or address of person who prov	vided you disclosures on eligible indire	ct compensa	tion

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

(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

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

	(a) Enter name and EIN or address (see instructions)					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(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 🗌
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(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 🗌
		(	a) Enter name and EIN or	address (see instructions)		
<b>(b)</b> Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(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 🗌

		(	a) Enter name and EIN or	address (see instructions)		
		( ))		(4)		(1)
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(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 🗌
		(	a) Enter name and EIN or	address (see instructions)		
<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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 🗍
		(	a) Enter name and EIN or	address (see instructions)		
<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(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

# 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.

(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
	for or the amount of the	he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect of	compensation, including any
	formula used to determine	the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect of	compensation, including any
	formula used to determine	the service provider's eligibility he indirect compensation.

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Part II Service Providers Who Fail or Refuse to	Provide Inform	nation
4 Provide, to the extent possible, the following information for ea this Schedule.	ach service provide	r 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
(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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i ugo	•	

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)		
a Name:	b EIN:	
C Position:		
d Address:	e Telephone:	
Explanation:		
a Name:	b EIN:	
C Position: d Address:	e Telephone:	
a Address.	e relepione.	
Explanation:		
a Name:	b EIN:	
C Position:		
d Address:	e Telephone:	
Furlesstice		
Explanation:		
a Name:	b EIN;	
C Position:		
d Address:	e Telephone:	
Explanation:		

а	Name:	<b>b</b> EIN;
С	Position:	
d	Address:	e Telephone:

Explanation: