Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 12/01/2000

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
SIGUE CORPORATION

13291 RALSTON AVENUE
SYLMAR, CA 91342

13291 RALSTON AVENUE
SYLMAR, CA 91342

2b Employer Identification Number (EIN)
51-0399296

2c Sponsor's telephone number
818-837-5939

2d Business code (see instructions)
522300

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.	12/29/2010	AMERICA VANDERBILT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

SIGUE CORPORATION
AMERICA VANDERBILT
13291 RALSTON AVENUE
SYLMAR, CA 91342

3b Administrator's EIN: 51-0399296

3c Administrator's telephone number: 818-493-5115

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

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	340
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	360
b	Retired or separated participants receiving benefits	**6b**	10
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	370
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

4A 4B 4C 4D 4F 4H 4J 4K

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

(1)		**R** (Retirement Plan Information)
(2)		**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)		**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)			**H** (Financial Information)
(2)			**I** (Financial Information – Small Plan)
(3)	X	8	**A** (Insurance Information)
(4)			**C** (Service Provider Information)
(5)			**D** (DFE/Participating Plan Information)
(6)			**G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
BLUE SHIELD OF CA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-6077403	61557	H54136, 943988	266	04/01/2009	03/31/2010

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
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

a [ ] Health (other than dental or vision) **b** [ ] Dental **c** [ ] Vision **d** [X] Life insurance

e [ ] Temporary disability (accident and sickness) **f** [ ] Long-term disability **g** [ ] Supplemental unemployment **h** [ ] Prescription drug

i [ ] Stop loss (large deductible) **j** [ ] HMO contract **k** [ ] PPO contract **l** [ ] Indemnity contract

m [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	9514
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
BLUE SHIELD OF CA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-0360524	47732	H54136,943988	386	04/01/2009	03/31/2010

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
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	1169444
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
FIDELITY SECURITY LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
43-0949844	71870	10799-1030	219	04/01/2009	03/31/2010

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
2342	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
CAMDEN INSURANCE AGENCY
3255 WILSHIRE BOULEVARD
LOS ANGELES, CA 90010

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1416			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
TRI-AD
221 WEST CREST STREET
SUITE 300
ESCONDIDO, CA 92025

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
926			3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	16346
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
KAISER FOUNDATION HEALTH PLANS

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1340523	0000	227649/600735	95	04/01/2009	03/31/2010

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
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	340090
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
UDC DENTAL OF CALIFORNIA, INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
33-0360239	52031	5346044	64	04/01/2009	03/31/2010

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
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	11316
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
UNION SECURITY INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
81-0170040	70408	5346044	163	04/01/2009	03/31/2010

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
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	144479
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	932206	96	04/01/2009	03/31/2010

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
91	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

USI OF SOUTHERN CALIFORNIA INS
WARNER CENTER TOWERS
21600 OXNARD STREET, 8TH FLOOR
WOODLAND HILLS, CA 91367

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
91			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	19125
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (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 2009 or fiscal plan year beginning 04/01/2009 and ending 03/31/2010

A Name of plan
SIGUE CORPORATION WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
SIGUE CORPORATION

D Employer Identification Number (EIN)
51-0399296

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 carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	932205	357	04/01/2009	03/31/2010

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
225	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

USI OF SOUTHERN CALIFORNIA INS
WARNER CENTER TOWERS
21600 OXNARD STREET, 8TH FLOOR
WOODLAND HILLS, CA 91367

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
225			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
e	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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**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)**	
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	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
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**	39681
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the 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. ▶

Form 5500 Schedule A Report for: SIGUE CORPORATION NCR
Group Code: 600735 Group Region: California
Report Period: 4/2009 - 3/2010

Part I
1. Coverage
(a) **Name of Insurance Carrier**
Kaiser Foundation Health Plans Inc.
Member Count: 12 Subscriber Count: 9

EIN: 94-1340523
NAIC: N/A

Premium paid to Kaiser Permanente: $ 41,583.71
2. Insurance Fees and Commissions
Total Commissions: $ 0.00 **Bonus: $** 0.00 **Non-Monetary: $** 1.08

(a) Name and address of agents, brokers, or other persons to whom commissions or fees were paid:
USI Of Southern California Insurance Services, Inc
21600 OXNARD ST STE 830 8th Floor
WOODLAND HILLS, CA 91367-4976

(b) Comms: $ 0.00 **(c) Bonus: $** 0.00 **(d) Non-monetary: $** 1.08
(d)Fees paid/Purpose
Gifts

Created: 12/20/2010 12:40:31 PM

Form 5500 Schedule A Report for: SIGUE CORPORATION SCR
Group Code: 227649 Group Region: California
Report Period: 4/2009 - 3/2010

Part I
1. Coverage
(a) **Name of Insurance Carrier**
Kaiser Foundation Health Plans Inc.
Member Count: 83 Subscriber Count: 60

EIN: 94-1340523
NAIC: N/A

Premium paid to Kaiser Permanente: $ 298,507.93
2. Insurance Fees and Commissions
Total Commissions: $ 0.00 **Bonus: $** 0.00 **Non-Monetary: $** 0.00

Created: 12/17/2010 5:06:10 PM

Form 5500 Schedule A Report for: SIGUE CORPORATION NCR
Group Code: 600735 Group Region: California
Report Period: 4/2009 - 3/2010

Part I
1. Coverage
(a) **Name of Insurance Carrier**
Kaiser Foundation Health Plans Inc.
Member Count: 12 Subscriber Count: 9

EIN: 94-1340523
NAIC: N/A

Premium paid to Kaiser Permanente: $ 41,583.71
2. Insurance Fees and Commissions
Total Commissions: $ 0.00 **Bonus: $** 0.00 **Non-Monetary: $** 1.08

(a) Name and address of agents, brokers, or other persons to whom commissions or fees were paid:
USI Of Southern California Insurance Services, Inc
21600 OXNARD ST STE 830 8th Floor
WOODLAND HILLS, CA 91367-4976

(b) Comms: $ 0.00 **(c) Bonus: $** 0.00 **(d) Non-monetary: $** 1.08
(d)Fees paid/Purpose
Gifts

Created: 12/20/2010 12:40:31 PM

Form 5500 Schedule A Report for: SIGUE CORPORATION SCR
Group Code: 227649 Group Region: California
Report Period: 4/2009 - 3/2010

Part I
1. Coverage
(a) **Name of Insurance Carrier**
Kaiser Foundation Health Plans Inc.
Member Count: 83 Subscriber Count: 60

EIN: 94-1340523
NAIC: N/A

Premium paid to Kaiser Permanente: $ 298,507.93
2. Insurance Fees and Commissions
Total Commissions: $ 0.00 **Bonus: $** 0.00 **Non-Monetary: $** 0.00

Created: 12/17/2010 5:06:10 PM

Form 5500 Schedule A Data

blue of california

CALIFORNIA PHYSICIANS' SERVICE Tax ID # 94-0360524, NAIC #47732

Group Number: H54136, 943988
Group Name: SIGUE CORP

Report Period: 4/1/2009 to 3/31/2010
Benefit Type: Medical: **YES** Drug: **YES** Vision: **NO**

Members/Subscribers: (End of Reporting Period) 386 / 265

Allocated Premiums: $1,169,444

Broker/Consultant Name	Address	From	Thru	Commissions	Fees Paid	Fees Paid Purpose
USI OF SO CALIF SVCS INC	P O BOX 4367 WOODLAND HILLS CA 91365	4/1/2009	3/31/2010	$0	$783	MVP allocation
					$96	Miscellaneous Gifts, Meals, Entertainment allocation
					$15	Producer Rewards Club allocation
					$894	

Source: rel_2010_1.0

blue of california

Blue Shield uses the following allocation methodologies in reporting 5500 data:

Compensation Received by Blue Shield

A. Pharmacy Manufacturer Retained Rebate (self-funded groups): Every quarter Blue Shield reconciles the pharmacy rebate payments received from manufacturers, and remits a portion of the payments (reimbursement amount as specified in contracts) back to self-funded groups either via a check or credit to claims reimbursement billing. An estimate of the remaining portion (retention amount) is used by Blue Shield to reduce administrative fees. This estimate is based on Blue Shield's self-funded book of business pharmacy rebate.

   The payments received from manufacturers are distributed at the employer group level based on the calculated reimbursement amounts. The reimbursement amount is calculated based on payments received at the rebate claim level.

Reportable Compensation Paid to Third Parties

A. Pharmacy Administration Fee (compensation to key vendors – self-funded groups): Blue Shield calculates a monthly per paid claim value based on invoice data; each employer group's portion is based on paid claim volumes for the months during the policy/contract timeframe.

B. Broker Bonus Override (monetary item): Blue Shield calculates a per member per month (pmpm) value per broker; each employer group's portion is calculated based on member months (mmos) for the policy/contract timeframe.

   - Bonus Override pmpm values for 2008 are calculated based on the 2008 year-end accrual amounts.

     2008 Example: $50,000 override year-end 2008 accrual for Broker A / 150,000 mmos for Broker A's book of business in 2008 x 3,000 mmos for Employer Group A for policy/contract year = $1,000 reported for plan year 2008.

   - Bonus Override pmpm values for 2009 will be based on the actual payments received in May 2010 and the type of bonus program.

     2009 Example: $45,510 Tier One override paid in 2010 for Broker A / 150,000 mmos for Broker A's book of business in 2009 x 3,000 mmos for Employer Group A = $910 reported for policy/contract year containing May 2010.

C. Marketing Allowances (monetary or non-monetary items): In cases where the allowances cannot be attributed to a specific group, Blue Shield calculates a pmpm value per broker per calendar year; each employer group's portion is based on member months for the policy/contract year.

   Example: $1,800 marketing allowance for Broker A / 150,000 mmos for Broker A's book of business x 3,000 mmos for Employer Group A = $36.

D. Producer Rewards Club (non-monetary item): Blue Shield calculates a pmpm value per broker based on the calendar-year redeemed value; each employer group's portion is based on member months for the policy/contract timeframe.

Example: $550 redeemed value for Broker A / 150,000 mmos for Broker A's book of business x 3,000 mmos for Customer A = $11.

E. MVP (non-monetary item): Blue Shield calculates a pmpm value for broker attendees based on membership for the year the award was earned; each employer group's portion is based on earned-year December membership and reported for the policy/contract timeframe containing the month the award was paid (June or July subsequent to the earned year).

Example: $4,800 MVP cost / 15,000 members for Broker A's x 250 members for Employer Group A = $80.

F. Miscellaneous Gifts, Meals and Expenses (non-monetary item):

- For mid/large accounts (51 to 3,000 eligible subscribers): Blue Shield sums the miscellaneous gifts, meals, and entertainment expenses excluding the portion (based on a sampling) of the costs related to clients and Blue Shield personnel. The net expenses are divided by the entire mid/large book of business member months for the calendar year to derive one overall per member per month (pmpm) value; each customer's portion is based on member months for the policy/contract timeframe. ***Note***: The amount reflected on the report does not reflect actual amounts (if any) received by an employer group's brokers/consultants.

- For Labor, Public, and Strategic (3,000+ eligible subscribers) accounts: Blue Shield allocates the broker/consultant portion of the expenses either to the specific employer groups involved or across the broker/consultant's entire book of business when a specific employer group cannot be identified.

SCHEDULE A
(Form 5500)

Insurance Information

Policyholder Name	Sigue Corporation
Policy Number	5346044
Information provided for time period	April 01, 2009 through March 31, 2010

Part I: Information Concerning Insurance Contract Coverage Fees and Commissions

Name of insurance carrier	**1(a)**	Union Security Insurance Company
EIN	**1(b)**	81-0170040
NAIC Code	**1(c)**	70408
Contract or identification number	**1(d)**	5346044
Policy or contract year	**1(f)**	April 01, 2009
	1(g)	March 31, 2010

1 Coverage	1(e) Approximate number of persons covered at end of policy or contract year	2(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount	2(e) Organization code
Group Dental Insurance **Dependent Dental**	163	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC 21600 OXNARD ST FL 8 WOODLAND HILLS, CA 91367	$.00		3

SCHEDULE A
(Form 5500)

Insurance Information

Totals by Coverage

1 Coverage	2(a) Name of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount
Group Dental Insurance Dependent Dental	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC	$.00	
Total		**$.00**	

SCHEDULE A
(Form 5500)

Insurance Information

Part III: Welfare Benefit Contract Information

7 Benefit and contract type	8 Experience-rated contracts	9 Nonexperience-rated contracts	
		9(a) Total premiums or subscription charges paid to carrier	9(b) Small Group Administrative fee paid
(b) Group Dental Insurance	N/A	$80,786.24	
(b) Dependent Dental	N/A	$63,693.04	

This Schedule A information provides information applicable to contracts you have with one or more of the companies described herein. On behalf of such underwriting companies, the designated officer signing below hereby certifies that the Schedule A information is complete and accurate.

Dianna D. Duvall

Dianna D. Duvall

12/16/2010

SCHEDULE A
(Form 5500)

Insurance Information

Policyholder Name	Sigue Corporation
Policy Number	5346044
Information provided for time period	April 01, 2009 through March 31, 2010

Part I: Information Concerning Insurance Contract Coverage Fees and Commissions

Name of insurance carrier	**1(a)**	Union Security Insurance Company
EIN	**1(b)**	81-0170040
NAIC Code	**1(c)**	70408
Contract or identification number	**1(d)**	5346044
Policy or contract year	**1(f)**	April 01, 2009
	1(g)	March 31, 2010

1 Coverage	1(e) Approximate number of persons covered at end of policy or contract year	2(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount	2(e) Organization code
Group Dental Insurance **Dependent Dental**	163	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC 21600 OXNARD ST FL 8 WOODLAND HILLS, CA 91367	$.00		3

SCHEDULE A
(Form 5500)

Insurance Information

Totals by Coverage

1 Coverage	2(a) Name of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount
Group Dental Insurance Dependent Dental	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC	$.00	
Total		**$.00**	

SCHEDULE A
(Form 5500)

Insurance Information

Part III: Welfare Benefit Contract Information

7 Benefit and contract type	8 Experience-rated contracts	9 Nonexperience-rated contracts	
		9(a) Total premiums or subscription charges paid to carrier	9(b) Small Group Administrative fee paid
(b) Group Dental Insurance	N/A	$80,786.24	
(b) Dependent Dental	N/A	$63,693.04	

This Schedule A information provides information applicable to contracts you have with one or more of the companies described herein. On behalf of such underwriting companies, the designated officer signing below hereby certifies that the Schedule A information is complete and accurate.

Dianna D. Duvall

Dianna D. Duvall

12/16/2010

Form 5500 Schedule A Data

blue of california

CALIFORNIA PHYSICIANS' SERVICE Tax ID # 94-0360524, NAIC #47732

Group Number: H54136, 943988
Group Name: SIGUE CORP

Report Period: 4/1/2009 to 3/31/2010
Benefit Type: Medical: **YES** Drug: **YES** Vision: **NO**

Members/Subscribers: (End of Reporting Period) 386 / 265

Allocated Premiums: $1,169,444

Broker/Consultant Name	Address	From	Thru	Commissions	Fees Paid	Fees Paid Purpose
USI OF SO CALIF SVCS INC	P O BOX 4367 WOODLAND HILLS CA 91365	4/1/2009	3/31/2010	$0	$783	MVP allocation
					$96	Miscellaneous Gifts, Meals, Entertainment allocation
					$15	Producer Rewards Club allocation
					$894	

Source: rel_2010_1.0

blue of california

Blue Shield uses the following allocation methodologies in reporting 5500 data:

Compensation Received by Blue Shield

A. Pharmacy Manufacturer Retained Rebate (self-funded groups): Every quarter Blue Shield reconciles the pharmacy rebate payments received from manufacturers, and remits a portion of the payments (reimbursement amount as specified in contracts) back to self-funded groups either via a check or credit to claims reimbursement billing. An estimate of the remaining portion (retention amount) is used by Blue Shield to reduce administrative fees. This estimate is based on Blue Shield's self-funded book of business pharmacy rebate.

   The payments received from manufacturers are distributed at the employer group level based on the calculated reimbursement amounts. The reimbursement amount is calculated based on payments received at the rebate claim level.

Reportable Compensation Paid to Third Parties

A. Pharmacy Administration Fee (compensation to key vendors – self-funded groups): Blue Shield calculates a monthly per paid claim value based on invoice data; each employer group's portion is based on paid claim volumes for the months during the policy/contract timeframe.

B. Broker Bonus Override (monetary item): Blue Shield calculates a per member per month (pmpm) value per broker; each employer group's portion is calculated based on member months (mmos) for the policy/contract timeframe.

   - Bonus Override pmpm values for 2008 are calculated based on the 2008 year-end accrual amounts.

     2008 Example: $50,000 override year-end 2008 accrual for Broker A / 150,000 mmos for Broker A's book of business in 2008 x 3,000 mmos for Employer Group A for policy/contract year = $1,000 reported for plan year 2008.

   - Bonus Override pmpm values for 2009 will be based on the actual payments received in May 2010 and the type of bonus program.

     2009 Example: $45,510 Tier One override paid in 2010 for Broker A / 150,000 mmos for Broker A's book of business in 2009 x 3,000 mmos for Employer Group A = $910 reported for policy/contract year containing May 2010.

C. Marketing Allowances (monetary or non-monetary items): In cases where the allowances cannot be attributed to a specific group, Blue Shield calculates a pmpm value per broker per calendar year; each employer group's portion is based on member months for the policy/contract year.

   Example: $1,800 marketing allowance for Broker A / 150,000 mmos for Broker A's book of business x 3,000 mmos for Employer Group A = $36.

D. Producer Rewards Club (non-monetary item): Blue Shield calculates a pmpm value per broker based on the calendar-year redeemed value; each employer group's portion is based on member months for the policy/contract timeframe.

Example: $550 redeemed value for Broker A / 150,000 mmos for Broker A's book of business x 3,000 mmos for Customer A = $11.

E. MVP (non-monetary item): Blue Shield calculates a pmpm value for broker attendees based on membership for the year the award was earned; each employer group's portion is based on earned-year December membership and reported for the policy/contract timeframe containing the month the award was paid (June or July subsequent to the earned year).

Example: $4,800 MVP cost / 15,000 members for Broker A's x 250 members for Employer Group A = $80.

F. Miscellaneous Gifts, Meals and Expenses (non-monetary item):

- For mid/large accounts (51 to 3,000 eligible subscribers): Blue Shield sums the miscellaneous gifts, meals, and entertainment expenses excluding the portion (based on a sampling) of the costs related to clients and Blue Shield personnel. The net expenses are divided by the entire mid/large book of business member months for the calendar year to derive one overall per member per month (pmpm) value; each customer's portion is based on member months for the policy/contract timeframe. ***Note***: The amount reflected on the report does not reflect actual amounts (if any) received by an employer group's brokers/consultants.

- For Labor, Public, and Strategic (3,000+ eligible subscribers) accounts: Blue Shield allocates the broker/consultant portion of the expenses either to the specific employer groups involved or across the broker/consultant's entire book of business when a specific employer group cannot be identified.

SCHEDULE A
(Form 5500)

Insurance Information

Policyholder Name	Sigue Corporation
Policy Number	5346044
Information provided for time period	April 01, 2009 through March 31, 2010

Part I: Information Concerning Insurance Contract Coverage Fees and Commissions

Name of insurance carrier	**1(a)**	UDC Dental of California, Inc
EIN	**1(b)**	33-0360239
NAIC Code	**1(c)**	52031
Contract or identification number	**1(d)**	5346044
Policy or contract year	**1(f)**	April 01, 2009
	1(g)	March 31, 2010

1 Coverage	1(e) Approximate number of persons covered at end of policy or contract year	2(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount	2(e) Organization code
DHMO/Prepaid Dental **DHMO/Prepaid Dependent Dental**	64	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC 21600 OXNARD ST FL 8 WOODLAND HILLS, CA 91367	$.00		3

SCHEDULE A
(Form 5500)

Insurance Information

Totals by Coverage

1 Coverage	2(a) Name of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount
DHMO/Prepaid Dental DHMO/Prepaid Dependent Dental	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC	$.00	
Total		**$.00**	

SCHEDULE A
(Form 5500)

Insurance Information

Part III: Welfare Benefit Contract Information

7 Benefit and contract type	8 Experience-rated contracts	9 Nonexperience-rated contracts	
		9(a) Total premiums or subscription charges paid to carrier	9(b) Small Group Administrative fee paid
(m) **DHMO/Prepaid Dental**	N/A	$8,090.86	
(m) **DHMO/Prepaid Dependent Dental**	N/A	$3,225.32	

This Schedule A information provides information applicable to contracts you have with one or more of the companies described herein. On behalf of such underwriting companies, the designated officer signing below hereby certifies that the Schedule A information is complete and accurate.

Dianna D. Duvall

Dianna D. Duvall

12/16/2010

SCHEDULE A
(Form 5500)

Insurance Information

Policyholder Name	Sigue Corporation
Policy Number	5346044
Information provided for time period	April 01, 2009 through March 31, 2010

Part I: Information Concerning Insurance Contract Coverage Fees and Commissions

Name of insurance carrier	**1(a)**	UDC Dental of California, Inc
EIN	**1(b)**	33-0360239
NAIC Code	**1(c)**	52031
Contract or identification number	**1(d)**	5346044
Policy or contract year	**1(f)**	April 01, 2009
	1(g)	March 31, 2010

1 Coverage	1(e) Approximate number of persons covered at end of policy or contract year	2(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount	2(e) Organization code
DHMO/Prepaid Dental **DHMO/Prepaid Dependent Dental**	64	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC 21600 OXNARD ST FL 8 WOODLAND HILLS, CA 91367	$.00		3

SCHEDULE A
(Form 5500)

Insurance Information

Totals by Coverage

1 Coverage	2(a) Name of the agents, brokers or other persons to whom commissions or fees were paid	2(b) Amount of commissions paid	2(c) Fees paid / amount
DHMO/Prepaid Dental DHMO/Prepaid Dependent Dental	USI OF SOUTHERN CALIFORNIA INSURANCE SERVICES INC	$.00	
Total		**$.00**	

SCHEDULE A
(Form 5500)

Insurance Information

Part III: Welfare Benefit Contract Information

7 Benefit and contract type	8 Experience-rated contracts	9 Nonexperience-rated contracts	
		9(a) Total premiums or subscription charges paid to carrier	9(b) Small Group Administrative fee paid
(m) **DHMO/Prepaid Dental**	N/A	$8,090.86	
(m) **DHMO/Prepaid Dependent Dental**	N/A	$3,225.32	

This Schedule A information provides information applicable to contracts you have with one or more of the companies described herein. On behalf of such underwriting companies, the designated officer signing below hereby certifies that the Schedule A information is complete and accurate.

Dianna D. Duvall

Dianna D. Duvall

12/16/2010

Avesis
A National Vision and Dental Company

Insurance Data for Schedule A Form 5500

Group #10799-1030
Insurance Carrier: Fidelity Security Life Insurance Company
Carrier NAIC Code No.: 71870 — Carrier EIN: 43-0949844
Administrator: Avesis Third Party Administrators, Inc. — Benefit Type: Vision Care
Policy or Contract Period: 4/01/2009 – 3/31/2010

Group Legal Name and Address:
Sigue Corporation
1518 San Fernando Road
San Fernando, CA 91340

Approximate Number of Persons Covered at the end of policy or contract period: 219 (117 employees)

Premium:

EE	$8.53	EE & Dep	$14.93	Family	$22.18

Total Premium Paid to Carrier $16,346.05

Commissions Paid for Contract Year:

Camden Insurance Agency 3255 Wilshire Blvd. Los Angeles, CA 90010	$ 1,416.70
Tri Ad Insurance 221 W. Crest Street Escondido, CA 92025	$ 926.26
Total commissions paid	$ 2,342.96

"Total Premium Paid to Carrier" listed above may differ from your records due to timing of posting payments, timing of employee payroll changes and our internal business practices related to the application of premium. For this reason we suggest you use your Accounts Payable or Payroll Records for reporting "Premium Paid to Carrier."

Avesis hereby certifies that this statement is furnished pursuant to 29 CFR 2520.103-5 (c) and is complete and accurate as of 12/17/2010.

Joel H. Alperstein
Chief Financial Officer

Avesis
A National Vision and Dental Company

Insurance Data for Schedule A Form 5500

Group #10799-1030
Insurance Carrier: Fidelity Security Life Insurance Company
Carrier NAIC Code No.: 71870 — Carrier EIN: 43-0949844
Administrator: Avesis Third Party Administrators, Inc. — Benefit Type: Vision Care
Policy or Contract Period: 4/01/2009 – 3/31/2010

Group Legal Name and Address:
Sigue Corporation
1518 San Fernando Road
San Fernando, CA 91340

Approximate Number of Persons Covered at the end of policy or contract period: 219 (117 employees)

Premium:

EE	$8.53	EE & Dep	$14.93	Family	$22.18

Total Premium Paid to Carrier $16,346.05

Commissions Paid for Contract Year:

Camden Insurance Agency 3255 Wilshire Blvd. Los Angeles, CA 90010	$ 1,416.70
Tri Ad Insurance 221 W. Crest Street Escondido, CA 92025	$ 926.26
Total commissions paid	$ 2,342.96

"Total Premium Paid to Carrier" listed above may differ from your records due to timing of posting payments, timing of employee payroll changes and our internal business practices related to the application of premium. For this reason we suggest you use your Accounts Payable or Payroll Records for reporting "Premium Paid to Carrier."

Avesis hereby certifies that this statement is furnished pursuant to 29 CFR 2520.103-5 (c) and is complete and accurate as of 12/17/2010.

Joel H. Alperstein
Chief Financial Officer

Form 5500 Schedule A Life/AD&D/Stop Loss

blue of california

BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY Tax ID # 94-6077403, NAIC #61557

Group Number: H54136, 943988
Group Name: SIGUE CORP

Report Period: 4/1/2009 to 3/31/2010
Benefit Type: Life: **YES** AD&D: **YES** Stoploss: **NO**

Members:
(End of Reporting Period) 266

Allocated Premiums: $9,514

Broker/Consultant Name	Address	From	Thru	Commissions	Fees Paid	Fees Paid Purpose
USI OF SO CALIF SVCS INC	P O BOX 4367 WOODLAND HILLS CA 91365	4/1/2009	3/31/2010	$0	$0	

Source: rel_2010_1.0

Form 5500 Schedule A Life/AD&D/Stop Loss

blue of california

BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY Tax ID # 94-6077403, NAIC #61557

Group Number: H54136, 943988
Group Name: SIGUE CORP

Report Period: 4/1/2009 to 3/31/2010
Benefit Type: Life: **YES** AD&D: **YES** Stoploss: **NO**

Members:
(End of Reporting Period) 266

Allocated Premiums: $9,514

Broker/Consultant Name	Address	From	Thru	Commissions	Fees Paid	Fees Paid Purpose
USI OF SO CALIF SVCS INC	P O BOX 4367 WOODLAND HILLS CA 91365	4/1/2009	3/31/2010	$0	$0	

Source: rel_2010_1.0

09/23/2010

SIGUE CORPORATION

HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION

13291 RALSTON AVENUE

SYLMAR CA 91342

00932206

M8\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: SIGUE CORPORATION

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

   Unum Life Insurance Company of America

   TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 932206

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 096

4. DATE FOR PERIOD: FROM 04-01-2009 TO 04-01-2010

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5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
USI of Southern California Ins Warner Center Towers 8th Fl 21600 Oxnard St Woodland Hills CA 91367	.00	.00	91.25

Hamilton, Curtis D .00 .00 .00

221 W Crest St Ste 300

Escondido CA 92025

USI Insurance Services Corp .00 .00 .00

555 Pleasantville Rd #160 S

Briarcliff Manor NY 10510

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6. COVERAGE/BENEFITS PROVIDED: LIFESTYLE ADD, LIFESTYLE LIFE

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 19,125.41

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ .00

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

M8\DM

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: SIGUE CORPORATION

1. Name of carrier, service or other organization:

   Unum Life Insurance Company of America

   Tax ID: 010278678 NAIC: 62235

2. Contract Number: 000000932206

3. Date for period: from 2009-04-01 to 2010-04-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid
No Additional Compensation		

09/23/2010

SIGUE CORPORATION

HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION

13291 RALSTON AVENUE

SYLMAR CA 91342

00932206

M8\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: SIGUE CORPORATION

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

   Unum Life Insurance Company of America

   TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 932206

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 096

4. DATE FOR PERIOD: FROM 04-01-2009 TO 04-01-2010

---

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
USI of Southern California Ins Warner Center Towers 8th Fl 21600 Oxnard St Woodland Hills CA 91367	.00	.00	91.25

Hamilton, Curtis D .00 .00 .00

221 W Crest St Ste 300

Escondido CA 92025

USI Insurance Services Corp .00 .00 .00

555 Pleasantville Rd #160 S

Briarcliff Manor NY 10510

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6. COVERAGE/BENEFITS PROVIDED: LIFESTYLE ADD, LIFESTYLE LIFE

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 19,125.41

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ .00

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

M8\DM

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: SIGUE CORPORATION

1. Name of carrier, service or other organization:

   Unum Life Insurance Company of America

   Tax ID: 010278678 NAIC: 62235

2. Contract Number: 000000932206

3. Date for period: from 2009-04-01 to 2010-04-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid
No Additional Compensation		

09/23/2010

SIGUE CORPORATION

HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION

1518 SAN FERNANDO RD.

SAN FERNANDO, CA 91350

00932205

M8\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: SIGUE CORPORATION

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

   Unum Life Insurance Company of America

   TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 932205

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 357

4. DATE FOR PERIOD: FROM 04-01-2009 TO 04-01-2010

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5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	ADDITIONAL FEES PAID	COMPENSATION PAID
USI of Southern California Ins Warner Center Towers 8th Fl 21600 Oxnard St Woodland Hills CA 91367	.00	.00	225.50

Hamilton, Curtis D .00 .00 .00

221 W Crest St Ste 300

Escondido CA 92025

USI Insurance Services Corp .00 .00 .00

555 Pleasantville Rd #160 S

Briarcliff Manor NY 10510

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6. COVERAGE/BENEFITS PROVIDED: ADD, LIFE, LTD

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 39,681.93

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ .00

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

M8\DM

09/23/2010

SIGUE CORPORATION

HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION

1518 SAN FERNANDO RD.

SAN FERNANDO, CA 91350

00932205

M8\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: SIGUE CORPORATION

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

   Unum Life Insurance Company of America

   TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 932205

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 357

4. DATE FOR PERIOD: FROM 04-01-2009 TO 04-01-2010

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5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	ADDITIONAL FEES PAID	COMPENSATION PAID
USI of Southern California Ins Warner Center Towers 8th Fl 21600 Oxnard St Woodland Hills CA 91367	.00	.00	225.50

Hamilton, Curtis D .00 .00 .00

221 W Crest St Ste 300

Escondido CA 92025

USI Insurance Services Corp .00 .00 .00

555 Pleasantville Rd #160 S

Briarcliff Manor NY 10510

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6. COVERAGE/BENEFITS PROVIDED: ADD, LIFE, LTD

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$ 39,681.93

(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$ .00

(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$ .00

M8\DM