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 06/01/2009 and ending 05/31/2010

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:
- [ ] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 06/01/2001

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
NORCAL RENTAL GROUP, LLC
CRESCO EQUIPMENT RENTALS

318 STEALTH COURT
LIVERMORE, CA 94551

318 STEALTH COURT
LIVERMORE, CA 94551

2b Employer Identification Number (EIN) 94-3263537

2c Sponsor's telephone number 925-961-0130

2d Business code (see instructions) 532400

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.	01/06/2011	ELISE REEDER
	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")
NORCAL RENTAL GROUP, LLC

318 STEALTH COURT
LIVERMORE, CA 94551

3b Administrator's EIN
94-3263537

3c Administrator's telephone number
925-961-0130

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**	190
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**	168
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	168
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	168
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 4D 4H

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number 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	4	**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 06/01/2009 and ending 05/31/2010

A Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
NORCAL RENTAL GROUP, LLC

D Employer Identification Number (EIN)
94-3263537

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 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
94-1340523	0	35768	86	06/01/2009	05/31/2010

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
9312	

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

DA CENTURY INSURANCE SERVICES, INC.
3470 MT DIABLO BLVD, STE A100
LAFAYETTE, CA 94549

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
9312	9	NON-MONETARY	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** [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** [ ] 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**	476369
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 06/01/2009 and ending 05/31/2010

A Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
NORCAL RENTAL GROUP, LLC

D Employer Identification Number (EIN)
94-3263537

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
PRINCIPAL 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
42-0127290	61271	N93139	165	06/01/2009	05/31/2010

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
5873	614

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
DA CENTURY INSURANCE SERVICES, INC.
3470 MT. DIABLO BLVD, STE A100
LAFAYETTE, CA 94549

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
5873	182	SERVICE FEE	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
NFP INSURANCE SERVICES, INC.
1250 S CAPITAL OF TX HWY
BLDG 2
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
	432	BONUS	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** [X] 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** [X] PPO contract	**l** [X] 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**	52511
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.**

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OMB No. 1210-0110

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 06/01/2009 and ending 05/31/2010

A Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
NORCAL RENTAL GROUP, LLC

D Employer Identification Number (EIN)
94-3263537

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
GUARDIAN 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
13-5123390	64246	00448463	169	07/01/2009	05/31/2010

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
4063	1391

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
DA CENTURY INSURANCE SERVICES, INC.
3470 MT. DIABLO BLVD, STE A100
LAFAYETTE, CA 94549

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4063	1391		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** [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**	137559
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 06/01/2009 and ending 05/31/2010

A Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
NORCAL RENTAL GROUP, LLC

D Employer Identification Number (EIN)
94-3263537

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
ANTHEM BLUE CROSS

(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	Policy or contract year (g) To
95-3760980	0	166301	81	06/01/2009	05/31/2010

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
27759	

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

DA CENTURY INSURANCE SERVICES, INC.
3470 MT. DIABLO BLVD, STE A100
LAFAYETTE, CA 94549

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
27759			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 (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code

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

(b) Amount of sales and base 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** [ ] 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**	555184
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. ▶

Anthem Blue Cross

WELFARE AND PENSION INSURANCE DATA

For use with:
U.S. Department of Treasury - IRS
U.S. Department of Labor - Form 5500

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

POLICY HOLDER: NORCAL RENTAL GROUP LLC DBA CRESCO

CONTRACT IDENTIFICATION: 166301

NAME OF CARRIER	Anthem Blue Cross
EIN	95-3760980
NAIC code	N/A

DATE PERIOD

FROM	6/1/2009
TO	6/1/2010

SUBSCRIBERS	EXPERIENCE	NON-EXPERIENCE
Life		
AD & D		
Disability		
Medical		81
Dental		
Vision		
EAP		
Pharmacy		

EXPERIENCE RATED CONTRACTS

PREMIUMS
- (1) AMOUNT RECEIVED
- (2) AMOUNT DUE BUT UNPAID
- (3) CHANGE IN UNEARNED PREMIUM RESERVE
- (4) PREMIUM EARNED (1-2-3)

BENEFIT CHANGES
- (1) CLAIMS PAID
- (2) CHANGES IN CLAIM RESERVE
- (3) CLAIMS INCURRED (1+2)
- (4) CLAIMS CHARGED

REMAINDER OF PREMIUM
- (1) RETENTION CHARGES
  - (A) COMMISSIONS
  - (B) ADMIN SERVICE OR OTHER FEES
  - (C) OTHER ACQUISITION COSTS
  - (D) OTHER EXPENSES
  - (E) TAXES
  - (F) CHARGES FOR RISK OR CONTINGENCIES
  - (G) OTHER RETENTION CHARGES
  - (H) TOTAL RETENTION
- (2) DIVIDENDS OR RETROACTIVE RATE RETURNS

(THESE AMOUNTS WERE__PAID IN CASH, OR__CREDITED.)

STATUS OF POLICYHOLDERS AT END OF YEAR
- (1) AMT. HELD TO PROVIDE BENEFITS AFTER RETIREMENT
- (2) CLAIM RESERVES
- (3) OTHER RESERVES

DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE

NON-EXPERIENCE RATED CONTRACTS

TOTAL PREMIUMS PAID $555,183.73

INSURANCE AND/OR ADMINISTRATIVE FEES AND COMMISSIONS PAID TO AGENTS AND BROKERS

CONTRACT OR ID#	NAME AND ADDRESS OF RECIPIENT	AMT. OF COMM.	FEES PAID*
83216	D/A CENTURY SERVICES INC. 3470 MT. DIABLO BLVD. STE. A100 LAFAYETTE, CA 94549	$27,759.19	$0.00

*Fees represent payments by the insurance carrier to agents, brokers or others for items other than commission including, but not limited to, business, overrides, or other fees.

Anthem Blue Cross hereby certifies that the foregoing statement furnished pursuant to 29 CRF 2520.103-5(c) is accurate and complete.

Jordan Nakatsuka
Regional Vice President, Underwriting

9/2/2010

KAISER PERMANENTE®

Report Period: 6/2009 - 5/2010

D/A CENTURY INSURANCE SERVICES, INC.
3470 MT DIABLO BLVD STE A100
LAFAYETTE, CA 94549-3958

Dear D/A CENTURY INSURANCE SERVICES, INC.:

Enclosed is a copy of the Schedule A, Form 5500 information that was sent to your client from Kaiser Foundation Health Plan, Inc. This is a duplicate of the information sent to the purchaser. You will no longer receive a summary of information, but a copy of each report sent to your clients. The enclosed report provides you with the following information:

- Total premium received by Kaiser Permanente within the group's plan contract year.
- Total commission, bonus, and non-monetary compensation **paid** (not earned) to brokers affiliated with your organization during your plan year (note; bonus dollars and non-monetary compensation are defined as "fees" on the actual 5500 form).
- Name of brokers receiving commissions, bonuses or non-monetary compensation.
- Purpose of non-monetary compensation paid to each broker.
- EIN and, if applicable, NAIC numbers.
- Member and subscriber counts.
- Group numbers.

Broker Copy

Brokers of record will automatically receive a copy of group reports from Kaiser Permanente. If you have an inquiry on a group that you are no longer a Broker of Record, please contact the Purchaser Service Unit at the number below. Reports are mailed within 120 days of the end of the group's contract year with Kaiser Permanente.

If you have any questions regarding the enclosed information, please call the Purchaser Service Unit at 1-866-752-4737. They will be able to answer your questions or direct you to the appropriate resource within the Kaiser Permanente Health Plan.

We at Kaiser Permanente value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our reporting practices for Schedule A Form 5500 reflect our shared commitment to full compliance with disclosure requirements. Thank you for your continued support.

Sincerely,

Kaiser Permanente

Form 5500 Schedule A Report for: NORCAL RENTAL GROUP, LLC DBA CRESCO EQUI

Group Code: 35768 **Group Region:** California

Report Period: 6/2009 - 5/2010

Part I

1. Coverage

(a) Name of Insurance Carrier **EIN:** 94-1340523

Kaiser Foundation Health Plans Inc. **NAIC:**N/A

Member Count: 132 Subscriber Count: 86

Premium paid to Kaiser Permanente: $476,369.17

2. Insurance fees and Commissions

Total Commissions: $9,311.54 **Bonus:** $0.00 **Non-Monetary:** $9.46

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

D/A Century Insurance Services, Inc.
3470 MT DIABLO BLVD STE A100 Suite A100
LAFAYETTE, CA 94549-3958

(b) Comms: $9,311.54 **(c) Bonus:** $0.00 **(d) Non-monetary:** $9.46

(d) Fees paid/Purpose

Gifts

Broker Copy

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

(b) Comms: $0.00 **(c) Bonus:** $0.00 **(d) Non-monetary:** $0.00

(d) Fees paid/Purpose

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

(b) Comms: $0.00 **(c) Bonus:** $0.00 **(d) Non-monetary:** $0.00

(d) Fees paid/Purpose

Kaiser Foundation Health Plan of California hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103-5(c) is complete and accurate.

Kaiser Foundation Health Plan, Inc. (California)

By ___

Printed Name: Wade J. Overgaard

Title: Senior Vice President, Sales and Account Management

Created: July 2, 2010

GUARDIAN

ELISE REEDER DIRECTOR
NORCAL RENTAL GROUP, LLC
318 STEALTH CT
LIVERMORE, CA 94550

August 09, 2010

Plan Number : 00448463
Anniversary Date : 6/1/2010

To help you with the preparation of your form 5500 (Annual Return / Report of Employee Benefit Plan ERISA) for filing with the Department of Labor, we are providing the following information.

You are required to transfer the information from this form to the appropriate schedule, forming Part of the 5500 form furnished by the United States Department of Labor. You will also need Guardian's Tax ID (EIN) and NAIC numbers, which are as follows :

EIC : 13-5123390

NAIC: 64246

A copy of this form should be retained for your records.

Certified to be correct

The Guardian Life Insurance Company of America.

Brant S. McCann

WRO Group Client Administration

Western Regional Office

P O Box 2454

Spokane, WA 99210-2454

1-800-459-9401

GUARDIAN

Name of Plan : **NORCAL RENTAL GROUP, LLC**

Plan Number : **00448463**

Data for Period From : **07/01/2009** To : **05/31/2010**

The approximate number of employees covered at the end of the plan year : 169

Group Insurance coverage(s) included under this Plan :

Dental (Insured)

The following figure represents commissions that are to be reported on Schedule A, Line 2, Element (b):

Contract Identification	Name and Address of Recipient of Commissions	Amount
SE896	D/A CENTURY INSURANCE SVCS, INC 3 ALTARINDA RD STE 300 ORINDA CA 94563	$4,063.39
	Total Commission Paid	**$4,063.39**

The following figure represents fees that are to be reported on Schedule A, Line 2, Element (c):

Contract Identification	Name of Recipient of Fees	Amount
SE896	D/A CENTURY INSURANCE SVCS, INC	$1,391.28
	Total Fees Paid	**$1,391.28**

However, the compensation listed above is not charged to your case in calculating new rates.

Premium due and unpaid at the end of plan year	:	$0.00
List gross premium for each contract	:	$137,559.16

GUARDIAN

Agency	Agent	Plan Number	Division Number	Cluster	ST	PN	Comm Type	Bill Due Date	Create Dt	Commission Amount
SE	896	00448463	0	T	DT	F0005A	Z	07/01/2009	07/17/2009	$759.12
SE	896	00448463	0	T	DT	F0012A	Z	07/01/2009	07/17/2009	$442.39
SE	896	00448463	0	T	DT	F0005A	Z	08/01/2009	09/04/2009	$516.29
SE	896	00448463	0	T	DT	F0005A	Z	09/01/2009	09/04/2009	$274.05
SE	896	00448463	0	T	DT	F0012A	Z	08/01/2009	09/04/2009	$300.88
SE	896	00448463	0	T	DT	F0012A	Z	09/01/2009	09/04/2009	$161.50
SE	896	00448463	0	T	DT	F0005A	Z	10/01/2009	10/09/2009	$189.82
SE	896	00448463	0	T	DT	F0012A	Z	10/01/2009	10/09/2009	$125.45
SE	896	00448463	0	T	DT	F0005A	Z	11/01/2009	11/13/2009	$117.96
SE	896	00448463	0	T	DT	F0012A	Z	11/01/2009	11/13/2009	$66.98
SE	896	00448463	0	T	DT	F0005A	Z	12/01/2009	11/30/2009	$118.76
SE	896	00448463	0	T	DT	F0012A	Z	12/01/2009	11/30/2009	$68.08
SE	896	00448463	0	T	DT	F0005A	Z	01/01/2010	01/29/2010	$113.66
SE	896	00448463	0	T	DT	F0005A	Z	02/01/2010	01/29/2010	$114.11
SE	896	00448463	0	T	DT	F0012A	Z	01/01/2010	01/29/2010	$67.04
SE	896	00448463	0	T	DT	F0012A	Z	02/01/2010	01/29/2010	$74.25
SE	896	00448463	0	T	DT	F0005A	Z	03/01/2010	03/05/2010	$113.06
SE	896	00448463	0	T	DT	F0012A	Z	03/01/2010	03/05/2010	$77.63
SE	896	00448463	0	T	DT	F0005A	Z	04/01/2010	04/09/2010	$110.62
SE	896	00448463	0	T	DT	F0012A	Z	04/01/2010	04/09/2010	$72.10
SE	896	00448463	0	T	DT	F0005A	Z	05/01/2010	05/07/2010	$113.06
SE	896	00448463	0	T	DT	F0012A	Z	05/01/2010	05/07/2010	$66.58
									Total	$4,063.39

GUARDIAN

Plan Number	Division Number	BT	BN	Bill Due Date	Create Date	Due Premium Amount
00448463	0	DT	F0005A	07/01/2009	07/17/2009	$8,015.57
00448463	0	DT	F0005A	08/01/2009	07/17/2009	$8,015.57
00448463	0	DT	F0005A	09/01/2009	08/18/2009	$8,051.06
00448463	0	DT	F0005A	10/01/2009	09/17/2009	$7,905.87
00448463	0	DT	F0005A	11/01/2009	10/19/2009	$7,863.77
00448463	0	DT	F0005A	12/01/2009	11/16/2009	$7,917.23
00448463	0	DT	F0005A	01/01/2010	12/16/2009	$7,576.93
00448463	0	DT	F0005A	02/01/2010	01/15/2010	$7,607.85
00448463	0	DT	F0005A	03/01/2010	02/16/2010	$7,537.72
00448463	0	DT	F0005A	04/01/2010	03/19/2010	$7,374.83
00448463	0	DT	F0005A	05/01/2010	04/16/2010	$7,537.72
00448463	0	DT	F0012A	07/01/2009	07/17/2009	$4,671.20
00448463	0	DT	F0012A	08/01/2009	07/17/2009	$4,671.20
00448463	0	DT	F0012A	09/01/2009	08/18/2009	$4,744.49
00448463	0	DT	F0012A	10/01/2009	09/17/2009	$5,225.32
00448463	0	DT	F0012A	11/01/2009	10/19/2009	$4,465.10
00448463	0	DT	F0012A	12/01/2009	11/16/2009	$4,539.14
00448463	0	DT	F0012A	01/01/2010	12/16/2009	$4,469.31
00448463	0	DT	F0012A	02/01/2010	01/15/2010	$4,949.84
00448463	0	DT	F0012A	03/01/2010	02/16/2010	$5,175.02
00448463	0	DT	F0012A	04/01/2010	03/19/2010	$4,806.42
00448463	0	DT	F0012A	05/01/2010	04/16/2010	$4,438.00
					Total	$137,559.16

GUARDIAN

Plan Number	Division Number	BT	BK	Bill Due Date	Check Date	Paid Premium Amount
00448463	0	DT	F0005A	07/01/2009	07/17/2009	$8,015.57
00448463	0	DT	F0005A	08/01/2009	09/03/2009	$8,015.57
00448463	0	DT	F0005A	09/01/2009	09/03/2009	$8,051.06
00448463	0	DT	F0005A	10/01/2009	10/08/2009	$7,905.87
00448463	0	DT	F0005A	11/01/2009	11/10/2009	$7,863.77
00448463	0	DT	F0005A	12/01/2009	11/30/2009	$7,917.23
00448463	0	DT	F0005A	01/01/2010	01/29/2010	$7,576.93
00448463	0	DT	F0005A	02/01/2010	01/29/2010	$7,607.85
00448463	0	DT	F0005A	03/01/2010	03/03/2010	$7,537.72
00448463	0	DT	F0005A	04/01/2010	04/08/2010	$7,374.83
00448463	0	DT	F0005A	05/01/2010	05/05/2010	$7,537.72
00448463	0	DT	F0012A	07/01/2009	07/17/2009	$4,671.20
00448463	0	DT	F0012A	08/01/2009	09/03/2009	$4,671.20
00448463	0	DT	F0012A	09/01/2009	09/03/2009	$4,744.49
00448463	0	DT	F0012A	10/01/2009	10/08/2009	$5,225.32
00448463	0	DT	F0012A	11/01/2009	11/10/2009	$4,465.10
00448463	0	DT	F0012A	12/01/2009	11/30/2009	$4,539.14
00448463	0	DT	F0012A	01/01/2010	01/29/2010	$4,469.31
00448463	0	DT	F0012A	02/01/2010	01/29/2010	$4,949.84
00448463	0	DT	F0012A	03/01/2010	03/03/2010	$5,175.02
00448463	0	DT	F0012A	04/01/2010	04/08/2010	$4,806.42
00448463	0	DT	F0012A	05/01/2010	05/05/2010	$4,438.00
					Total	$137,559.16

Broker Copy

Principal Life Insurance Company
Des Moines, IA 50392
(515) 247-5111

Kathy

July 28, 2010

NORCAL RENTAL GROUP, LLC
ATTN ELISE REEDER
318 STEALTH CT
LIVERMORE CA 94551-9303

Re Acct No. N93139

Enclosed is your Schedule A (Form 5500) worksheet for the period June 1, 2009 through your May 31, 2010 termination date. Most insured welfare benefit plans of 100 or more plan participants are required to file a Form 5500 with the Department of Labor. If applicable, the enclosed Schedule A worksheet will be needed to complete the Form 5500. Please review your plan for filing implications.

Further information on Form 5500 can be viewed at www.dol.gov/ebsa. As of January 1, 2010, the Department of Labor requires most filings to be submitted electronically. To electronically file your Form 5500, see www.efast.dol.gov. Additional help with EFAST can be obtained by calling the EFAST help line at 1-866-GO-EFAST (1-866-463-3278).

Thank you for allowing Principal Life Insurance Company the opportunity to provide for your insurance needs. If you have questions about the enclosed information, please contact me at the number listed below.

Sincerely,

David M Decker
Principal Financial Group
Group Underwriting—EPR Unit
Phone 1-800-986-3343
Press '1' for Directory Assistance, Ext. 84216

Enclosure

cc:

D/A CENTURY INSURANCE
3470 MT DIABLO BLVD
STE A100
LAFAYETTE CA 94549-2601

Principal Financial Group



Principal Life Insurance Company
Des Moines, Iowa 50392-0001 Schedule A (Form 5500)

Information needed from insurer to complete the Annual Report Schedule A Part I

Data for Period June 01, 2009 to May 31, 2010

Name of Plan CRESCO Three Digit Plan Number - -

Name of Sponsor _____ Employer ID Number -

1. Coverage

Name of Insurance Carrier (A)	EIN (B)	NAIC Code (C)	Contract or Identification Number (D)	Approx. no. of Persons cov. At End of Policy Year (E)
Principal Life Insurance Company	42-0127290	61271	N93139	165

Policy or Contract Year From (F) 06/01/2009 To (G) 05/31/2010

Combined Numbers

2. Insurance fee and commission information

Total	Amount of Commissions Paid	Fees paid / Amount
	5,873	614

3. Persons receiving commissions and fees

Name & Address of Agents or Brokers to whom Commissions or Fees Paid (A)	Amount of Commissions Paid (B)	Fees Paid Amount (C)	Fees Paid Purpose (D)
NFP INSURANCE SERVICES INC 1250 S CAPITAL OF TX HWY BLDG 2 AUSTIN TX 78746-6464		432	* Bonus
(E) Organizational Code: _3_			
D/A CENTURY INSURANCE SERVICES IN 3470 MT DIABLO BLVD STE A100 LAFAYETTE CA 94549-2601	5,873	182	Service Fee
(E) Organizational Code: _3_			

(E) Organizational codes.

1 - Banking, Savings & Loan Assoc., Credit Union or other similar financial institution
2 - Trust Co
3 - Insurance Agent or Broker
4 - Agent or Broker other than Ins.
5 - Third Party Administrator
6 - Investment Co/Mutual Fund
7 - Investment Manager/Advisor
8 - Labor Union
9 - Foreign Entity
0 - Other

* This compensation amount is the amount paid. It is not the actual cost charged. This amount is an administrative expense allocated across all policies sold by Principal Life Insurance Company.

Principal Life
Insurance Company
Des Moines, Iowa 50392-0001

Schedule A (Form 5500)

Part III - Welfare Benefit Contract Information

8. Benefit and Contract Type

(A)	Health (other than Dental or Vision)	(B)	X	Dental	(C)		Vision	(D)	X	Life Ins.
(E)	Temporary Disability (accident and sickness)	(F)	X	Long Term Disability	(G)		Supplemental Unemployment	(H)		Prescription Drug
(I)	Stop Loss (Large Ded)	(J)		HMO Contract	(K)	X	PPO Contract	(L)	X	Indemnity Contract
(M)	Other (specify Below)									

9. Experience Rated Contracts

A. Premiums
- (1) Amount Received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned, (1) Plus (2) Minus (3)

B. Benefit Charges
- (1) Claims Paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred Claims (add (1) and (2))
- (4) Claims Charged

C. Remainder of Premium
- (1) Retention Charges (on an Accrual Basis)
  - (A) Commissions
  - (B) Administrative Service or Other Fees
  - (C) Other Specific Acquisition Costs
  - (D) Other Expenses
  - (E) Taxes
  - (F) Charges for Risks or other contingencies
  - (G) Other Retention Charges
  - (H) Total Retention
- (2) Dividends or Retroactive Rate Refunds
  Above Amounts Paid in Cash

D. Status of Policyholder Reserves at End ofY ear
- (1) Amount Held to Provide Benefits after Retirement
- (2) Claim Reserves
- (3) Other Reserves - Premium Stabilization Reserve

E. Dividends or Retroactive Rate Refunds Due
(Do not include amount entered in (C)(2))

10. Non Experience Rated Contracts

A. Total Premiums or Subscription Charges Paid to Carrier	52,511
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 1, item 2 above, report amount	None

Policies Terminated May 31, 2010. This report includes figures as of that date.
Contract Number N93139
Name of Plan CRESCO

Data for Period June 01, 2009 to May 31, 2010