Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2010

	, , , , , , , , , , , , , , , , , , , ,				Inis Form is Open to Public Inspection				
Part I	Annual Report Iden	tification Information							
For cale	For calendar plan year 2010 or fiscal plan year beginning 02/01/2010 and ending 01/31/2011								
A This	eturn/report is for:	a multiemployer plar	n; 📗 a multip	le-employer plan; or					
a single-employer plan; a DFE (specify)									
B This	eturn/report is:	the first return/report	t; the final	return/report;					
		an amended return/i	report; a short	plan year return/report (l	ess than 12 months).				
C If the	plan is a collectively-bargaine	ed plan, check here	-						
D Chec	k box if filing under:	☐ Form 5558;	□ automa	tic extension;	the DFVC program;				
2 0.100	K BOX II IIIIII g dildor.	special extension (e		,					
Part	II Rasic Plan Inform	nation—enter all requested	. ,						
	ne of plan	ination—enter an requested	imomation		1b Three-digit plan 501				
	OODS INC HEALTH AND WI	ELFARE PLAN			number (PN) ▶				
					1c Effective date of plan 02/01/2010				
	sponsor's name and address		nployer plan)		2b Employer Identification				
,	ress should include room or s OODS INC	suite no.)			Number (EIN) 26-3363922				
					2c Sponsor's telephone number				
	E WEBER				502-772-2500				
	MAGNOLIA AVENUE ILLE, KY 40211		'01 W MAGNOLIA AVENUI DUISVILLE, KY 40211	E	2d Business code (see				
	,		instructions) 311800						
					311600				
Caution	: A penalty for the late or in	complete filing of this retu	rn/report will be assessed	l unless reasonable ca	use is established.				
Under pe	enalties of perjury and other p	enalties set forth in the instru	ictions, I declare that I have	e examined this return/re	port, including accompanying schedules,				
statemer	nts and attachments, as well a	as the electronic version of th	is return/report, and to the	best of my knowledge ar	nd belief, it is true, correct, and complete.				
SIGN HERE	Filed with authorized/valid ele	ectronic signature.	07/26/2011	SHERRIE WEBER					
HEKE	Signature of plan adminis	trator	Date	Enter name of individ	lual signing as plan administrator				
SIGN									
HERE	Signature of employer/pla	n sponsor	Date	Enter name of individ	lual signing as employer or plan sponsor				
SIGN									
HERE									

Date

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

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

Form 5500 (2010)	Page 2
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	Plan administrator's name and address (if same as plan sponsor, enter "Sar SA FOODS INC	me")		inistrator's EIN 863922
370	RRIE WEBER 1 W MAGNOLIA AVENUE JISVILLE, KY 40211		num	nistrator's telephone ber 772-2500
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for this plan, enter the name, EIN	and 4	lb EIN
а	Sponsor's name		4	IC PN
5	Total number of participants at the beginning of the plan year		5	191
6	Number of participants as of the end of the plan year (welfare plans comple	te only lines 6a, 6b, 6c, and 6d).		
а	Active participants		. 6a	192
b	Retired or separated participants receiving benefits		. 6b	2
С	Other retired or separated participants entitled to future benefits		. 6c	
d	Subtotal. Add lines 6a , 6b , and 6c		. 6d	194
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits	. 6e	
f	Total. Add lines 6d and 6e		. 6f	194
g	Number of participants with account balances as of the end of the plan year complete this item)		6g	
	,		· og	
h	Number of participants that terminated employment during the plan year wit less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only	y multiemployer plans complete this item)	7	
b If	If the plan provides pension benefits, enter the applicable pension feature of the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4F 4H			
9a	Plan funding arrangement (check all that apply) (1) Insurance	9b Plan benefit arrangement (check all that (1) Insurance	at apply)	
	(1) Insurance (2) Code section 412(e)(3) insurance contracts	(1) Insurance Code section 412(e)(3)	insurance	contracts
	(3) Trust	(3) Trust		33111.4313
	(4) General assets of the sponsor	(4) General assets of the sp	onsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are	attached, and, where indicated, enter the number	oer attache	ed. (See instructions)
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	,	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Inform		nall Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X A (Insurance Infor	,	
		(4) C (Service Provide		,
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participati	•	,
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction Sch	ieuules)

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

OMB No. 1210-0110

2010

						Inspection
For calendar plan year 20	10 or fiscal plan	year beginning 02/01/2010	and e	nding 01/31	1/2011	
A Name of plan MESA FOODS INC HEAL	_TH AND WELF	FARE PLAN		e-digit number (PN))	501
C Plan sponsor's name as shown on line 2a of Form 5500. MESA FOODS INC D Employer Identification Number (I 26-3363922						EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca		ANY				
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ntract year
(b) EIN	(c) NAIC code	identification number	persons covered at end of policy or contract year	(f) F	rom	(g) To
81-0170040	70408	7013676A	55	02/01/2010)	01/31/2011
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 a	amount of comn		(b) To	otal amount of	fees paid	
		1117				355
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all persons).			
	(a) Name a	nd address of the agent, broker, o	•	sions or fees w	ere paid	
THE ABACUS GROUP L	LC		AFAYETTE PLAZA DRIVE IY, GA 31707			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	274					3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
INSURAMAX INC 2200 GREENE WAY LOUISVILLE, KY 40220						
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	557					3
For Donomyork Bodyotic	n Act Notice c	nd OMP Control Numbers and	the instructions for Form FEOO		Cab	dula A (Farm FEOO) 2010

Schedule A (Form 5500)	2010	Page 2-	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
ABACUS BENEFITS MANAGEMENT	LLC POB	OX 33022 (VILLE, TN 37930	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
285	(e) runeant	(a) i dipode	3
(-) NI-	and address of the ansat heal of		•
THE ABACUS GROUP LLC	252 H	r, or other person to whom commissions or fees were pa ARRY LANE BLVD SUITE 100 (VILLE, TN 37923	uid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	53	MARKETING FEE	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
ADMINISTRATIVE SYSTEMS INC		UEEN ANNE AVE NORTH SUITE 200 TLE, WA 98109	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount 167	(d) Purpose ADMINISTRATIVE FEE	code 5
DISABILITY RMS INC	ONE I	r, or other person to whom commissions or fees were pa RIVERFRONT PLAZA IBROOK, ME 04092	iid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	100	CLAIMS ADMINISTRATIVE SERVICES	5
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
TOWERS PERRIN FORSTER & CRO	DSBY INC MELL 1735	ON BANK CENTER MARKET STREET ADELPHIA, PA 19103	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	34	FINDERS FEE	3

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Pa	art II	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carri	er may be treated as a un	it for purposes of
4	Curr	this report. ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in the general accounts at year e			
_		racts With Allocated Funds:			
•	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	2326
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount	•	nu l	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts		
	а	Type of contract: (1)	ate participation guarantee		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)	·	
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	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	
	е	Deductions:	- (1)		
		(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	

Page	4

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

Part III

Welfare Benefit Contract Information

8	3en	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	b	Dental	С	Vision		d 📗 ∟	ife insurance
	е	Temporary disability (accident and sickness)	f	Long-term disabilit	y g	Supplemental unemp	oloyment	h∏P	rescription drug
	i	Stop loss (large deductible)	i 🗏	HMO contract	k 🗏	PPO contract		ı∏ır	ndemnity contract
	m	Other (specify)	•		<u> </u>]		- Ш "	adminity demination
,	F	_ cuter (specify)							
9 E	Ехре	erience-rated contracts:							
	•	Premiums: (1) Amount received			9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid			9a(2)			Ī	
		(3) Increase (decrease) in unearned premium rese			9a(3)				
		(4) Earned ((1) + (2) - (3))		_			9a(4)		
	b	Benefit charges (1) Claims paid			9b(1)				
		(2) Increase (decrease) in claim reserves			9b(2)				
		(3) Incurred claims (add (1) and (2))					9b(3)		
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (or	n an a	ccrual 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		i	9c(1)(D)			4	
		(E) Taxes		h h	9c(1)(E)			_	
		(F) Charges for risks or other contingencies		ħ	9c(1)(F)			_	
		(G) Other retention charges		-	9c(1)(G)		00/41/111		
		(H) Total retention					9c(1)(H)		
	-1	(2) Dividends or retroactive rate refunds. (These							
	d	Status of policyholder reserves at end of year: (1)		•			9d(1)		
		(2) Claim reserves					9d(2)		
	_	(3) Other reserves Dividends or retroactive rate refunds due. (Do no					9d(3) 9e		
10		enexperience-rated contracts:	t IIICI	ude amount entered	III C(2).)		96		
	a	Total premiums or subscription charges paid to ca	arrier				10a		
	b	If the carrier, service, or other organization incurre					100		
		retention of the contract or policy, other than repo				•	10b		
	Sp	pecify nature of costs							
Pa	rt I	V Provision of Information							
11	Dic	d the insurance company fail to provide any informa	ation	necessary to comple	ete Schedule	A?	Yes	X No	
12	If t	he answer to line 11 is "Yes," specify the information	on no	t 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

OMB No. 1210-0110

2010

nurought to EDICA goation 102(a)(2)					rm is Open to Public Inspection			
For calendar plan year 20	10 or fiscal pla	n year beginning 02/01/2010	and e	ending 01/31/2011	•			
A Name of plan MESA FOODS INC HEAL	_TH AND WEI	FARE PLAN		ee-digit n number (PN)	501			
C Plan sponsor's name a MESA FOODS INC	C Plan sponsor's name as shown on line 2a of Form 5500. MESA FOODS INC D Employer Identification Number (EIN) 26-3363922							
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca		DMPANY OF AMERICA						
		1	(e) Approximate number of	Policy or o	ontract year			
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To			
13-5123390	64246	00445131	146	02/01/2010	01/31/2011			
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. List in item	3 the agents, brokers, and	other persons in			
(a) Total a	amount of com	missions paid	(b) T	otal amount of fees paid				
		7993			0			
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all persons).					
	(a) Name		r, or other person to whom commis	sions or fees were paid				
BROWN & BROWN OF R	KENTUCKY		5 FREDERICA STREET ENSBORO, KY 42301					
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid					
commissions pa		(c) Amount	(d) Purpos	(e) Organization code				
7993								
	(a) Name	and address of the agent, broke	r, or other person to whom commis	sions or fees were paid	_			
	(a) Name	and address of the agent, broke	r, or other person to whom commo	sions of rees were para				
(b) Amount of sales ar	nd hase	Fe	ees and other commissions paid					
commissions pa	id	(c) Amount	(d) Purpos	(d) Purpose				

Schedule A (Form 5500)	2010	Page 2-		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code
	(o) runount		(a) i dipoco	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

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Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	idual contracts wit	n each carrier may	he treated	las a unit for nurnoses of
		this report.	iddai coritiacis witi	r cacir carrier may	be treated	a as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	64800
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check h	ere 🕨		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	te accounts)		
	а		te participation gu			
		(3) guaranteed investment (4) other				
		(o) guaranteed investment				
	L	Delegan at the conduct the constitution			7h	
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(4)			
		(4) Transferred from separate account	7c(5)			
		(5) Other (specify below)	10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add b and c(6))			7d	
	е	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)			76(3)	
		- Land of the carroin your (bublicut b(b) from a)				

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Part III

Welfare Benefit Contract Information

		ne answer to line 11 is "Yes," specify the information			p.0.00 00.100				
11	Did	the insurance company fail to provide any informa	ation	necessary to com	plete Sched	ule	A?	Yes	No No
Par	t IV	Provision of Information							
	Sp	ecify nature of costs 🕨							
		If the carrier, service, or other organization incurre retention of the contract or policy, other than repo					•	10b	
	a	Total premiums or subscription charges paid to ca	arrier					10a	
		nexperience-rated contracts:			,,,				
	е	Dividends or retroactive rate refunds due. (Do no					_	9e	
		(3) Other reserves						9d(2) 9d(3)	
	d	(2) Claim reserves						9d(1)	
	A	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (1)		<u> </u>	<u> </u>	_		9c(2)	
		(H) Total retention		_	_	_	<u> </u>	9c(1)(H))
		(G) Other retention charges				-		0c/4\/L\	
		(F) Charges for risks or other contingencies							
		(E) Taxes				_			
		(D) Other expenses			9c(1)(D)			
		(C) Other specific acquisition costs			0 (4)(0)				
		(B) Administrative service or other fees			- (1)(-				
	•	(A) Commissions		•	9c(1)(A) [
		Remainder of premium: (1) Retention charges (or					····· <u></u>	05(4)	
		(4) Claims charged(4)					<u> </u>	9b(4)	
		(2) Increase (decrease) in claim reserves(3) Incurred claims (add (1) and (2))						9b(3)	
		Benefit charges (1) Claims paid(2) Increase (decrease) in claim reserves				\dashv			
		(4) Earned ((1) + (2) - (3))				····		9a(4)	
		(3) Increase (decrease) in unearned premium rese					1	0-(4)	
		(2) Increase (decrease) in amount due but unpaid				4			
á		Premiums: (1) Amount received			` ` `				
9 E	хре	rience-rated contracts:							
r	n	Other (specify)							
ı	L	Stop loss (large deductible)	j L	HMO contract	k	: <u> </u>	PPO contract		I Indemnity contract
	? [] ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	f [_ ~	, ,	Ξ	Supplemental unempl	oyment	h ☐ Prescription drug
	a [Health (other than dental or vision)		Dental				_	d X Life insurance
		offit and contract type (check all applicable boxes)	h X	1 Dantal		X	1 \/:=:==		d X 1:42 :
8 E	2000	stit and contract type (about all applicable bayes)							
		the entire group of such individual contracts w	ith e	acn carrier may be	treated as a	a ur	nit for purposes of this r	eport.	

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.

OMB No. 1210-0110

2010

pursuant to ERISA section 103(a)(2). This Form is										
For calendar plan year 2010 or fiscal plan year beginning 02/01/2010 and ending 01/31/2011										
A Name of plan MESA FOODS INC HEAL	TH AND WEL	FARE PLAN		hree-digit blan number (PN)	501					
C Plan sponsor's name as shown on line 2a of Form 5500. MESA FOODS INC D Employer Identification Number (EIN) 26-3363922										
	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 can ANTHEM HEALTH PLAN		CKY INC								
(L) FIN	(c) NAIC	(d) Contract or	(e) Approximate number of		olicy or contract year					
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To					
61-1237516	95120	000009552	194	02/01/2010	01/31/2011					
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. List in ite	m 3 the agents, broke	ers, and other persons in					
(a) Total a	amount of com	missions paid	(b) Total amount of fees	s paid					
	27620									
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all persons	s).						
	(a) Name a	and address of the agent, broker	, or other person to whom comn	nissions or fees were	paid					
BROWN AND BROWN O	F KENTUCKY		5 FREDERICA STREET ENSBORO, KY 42301							
(b) Amount of sales ar	nd base	Fe	es and other commissions paid							
commissions pai		(c) Amount	(d) Purp	oose	(e) Organization code					
	27620									
	(a) Name a	and address of the agent, broke	r, or other person to whom comn	nissions or fees were	paid					
(b) Amount of sales ar	nd base	Fe	es and other commissions paid							
commissions pai	d	(c) Amount	(d) Purp	oose	(e) Organization code					

Schedule A (Form 5500)	2010	Page 2-							
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid						
(b) Amount of sales and base		Fees and other commission		(e) Organization					
commissions paid	(c) Amount		(d) Purpose	code					
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid						
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid						
(b) Amount of sales and base		Fees and other commission		(e) Organization					
commissions paid	(c) Amount		(d) Purpose	code					
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid						
(a) No	and and address of the agent, prone	w, or other percent to whem	COMMISSIONIC OF 1000 WORD PAIG						
		Face and other commission	ao naid						
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	(d) Purpose	(e) Organization code					
	(o) runount		(a) i dipoco						
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid						
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization					
commissions paid	(c) Amount		(d) Purpose	code					
	• •								
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid						
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization					
commissions paid	(c) Amount		(d) Purpose	code					

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D:	art II	Investment and Annuity Contract Information			
Pā	art II	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each o	carrier may be treated as a unit	for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	639384
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre (3) other (specify)	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check here	▶ ∏	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accor	unts)	
	а	` ·	ate participation guarantee	•	
		(3) guaranteed investment (4) other	· · · · · ·		
		(b) guaranteed investment (1) care.			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	- (a)		
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add b and c(6))		7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			

Page	4

Pa	art I	Welfare Benefit Contract Informati If more than one contract covers the same gro information may be combined for reporting put the entire group of such individual contracts w	up of employees of the sposes if such contracts	are experi	ience-	rated as a unit. Whe	re contrac	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	C	c 🗌 🗎	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty Q	g∏s	Supplemental unemp	loyment	h Prescription drug
	i İ	Stop loss (large deductible)	j HMO contract		~ <u></u>	PPO contract	•	I Indemnity contract
	m		, rime contract	-	∵⊔.	T O contract		I I indemnity contract
	m	Other (specify)						
9	Evn	erience-rated contracts:						
9		Premiums: (1) Amount received		9a(1)				
	u	(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium rese		9a(3)				
		(4) Earned ((1) + (2) - (3))	•				9a(4)	
	b	Benefit charges (1) Claims paid					5 4(1)	
		(2) Increase (decrease) in claim reserves		/->				
		(3) Incurred claims (add (1) and (2))					9b(3)	
		(4) Claims charged				ħ	9b(4)	
	С	Remainder of premium: (1) Retention charges (or				L		
		(A) Commissions		9c(1)(A	(۱			
		(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	3)			
		(H) Total retention			<u></u>		9c(1)(H)
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	cre	edited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits af	fter re	etirement	9d(1)	
		(2) Claim reserves					9d(2)	
		(3) Other reserves					9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	l in c(2) .) .			9e	
10) No	nexperience-rated contracts:				Г		
	a	Total premiums or subscription charges paid to ca					10a	
	b	If the carrier, service, or other organization incurrer retention of the contract or policy, other than repo					10b	
	Sr	pecify nature of costs	tod iii i dit i, itolii 2 abov	vo, roport	arriou	······	102	
	- 1	, , , , , , , , , , , , , , , , , , , ,						
D	re l'	V Provision of Information						
	art l							XI N.
11	l Di	d the insurance company fail to provide any informa	ation necessary to compl	ete Sched	dule A	١?	Yes	X No