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|---|---|---|
| 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 <u>01/01/2009</u> and ending <u>12/31/2009</u> | |
| A This return/report is for: | <input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____ |
| B This return/report is: | <input checked="" type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input checked="" type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months). |
| C If the plan is a collectively-bargained plan, check here. | <input type="checkbox"/> |
| D Check box if filing under: | <input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description) |

| | | | | | | | |
|---|--|--|------------|--------------------------------------|--------------|--|--------|
| Part II | Basic Plan Information —enter all requested information | | | | | | |
| 1a Name of plan MATRIX EMPLOYEE LEASING INC MINI-MED PLAN | <table border="1"> <tr> <td>1b Three-digit plan number (PN) ▶</td> <td>002</td> </tr> <tr> <td>1c Effective date of plan</td> <td>06/17/2007</td> </tr> </table> | 1b Three-digit plan number (PN) ▶ | 002 | 1c Effective date of plan | 06/17/2007 | | |
| 1b Three-digit plan number (PN) ▶ | 002 | | | | | | |
| 1c Effective date of plan | 06/17/2007 | | | | | | |
| 2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) MATRIX EMPLOYEE LEASING INC 9016 PHILIPPS HWY JACKSONVILLE, FL 32256 | <table border="1"> <tr> <td>2b Employer Identification Number (EIN)</td> <td>59-3610674</td> </tr> <tr> <td>2c Sponsor's telephone number</td> <td>904-739-2722</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td>561410</td> </tr> </table> | 2b Employer Identification Number (EIN) | 59-3610674 | 2c Sponsor's telephone number | 904-739-2722 | 2d Business code (see instructions) | 561410 |
| 2b Employer Identification Number (EIN) | 59-3610674 | | | | | | |
| 2c Sponsor's telephone number | 904-739-2722 | | | | | | |
| 2d Business code (see instructions) | 561410 | | | | | | |

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 | | | |
| | 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") MATRIX EMPLOYEE LEASING INC 9016 PHILIPPS HWY JACKSONVILLE, FL 32256 | 3b Administrator's EIN 59-3610674 3c Administrator's telephone number 904-739-2722 |
| 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 |
| 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 |
| b Retired or separated participants receiving benefits..... | 6b |
| c Other retired or separated participants entitled to future benefits..... | 6c |
| d Subtotal. Add lines 6a , 6b , and 6c | 6d |
| 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: | |

| | |
|---|---|
| 9a Plan funding arrangement (check all that apply) | 9b Plan benefit arrangement (check all that apply) |
| (1) <input type="checkbox"/> Insurance | (1) <input type="checkbox"/> Insurance |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts |
| (3) <input type="checkbox"/> Trust | (3) <input type="checkbox"/> Trust |
| (4) <input type="checkbox"/> General assets of the sponsor | (4) <input type="checkbox"/> 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 | b General Schedules |
| (1) <input type="checkbox"/> R (Retirement Plan Information) | (1) <input type="checkbox"/> H (Financial Information) |
| (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | (2) <input type="checkbox"/> I (Financial Information – Small Plan) |
| (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | (3) <input type="checkbox"/> A (Insurance Information) |
| | (4) <input type="checkbox"/> C (Service Provider Information) |
| | (5) <input type="checkbox"/> D (DFE/Participating Plan Information) |
| | (6) <input type="checkbox"/> G (Financial Transaction Schedules) |

59-3610674P

Official Use Only
OMB Nos. 1210-0110 / 1210-0089

2007 200806

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 under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2007 or fiscal plan year beginning

06 17 2007

and ending

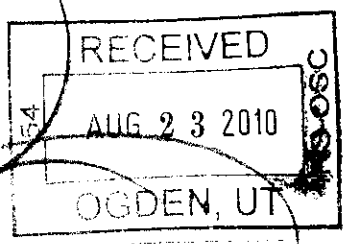
06 14 2008

- A This return/report is for: (1) a multiemployer plan; (3) a multiple-employer plan; or
- (2) a single-employer plan (other than a multiple-employer plan); (4) a DFE (specify)
- B This return/report is: (1) the first return/report filed for the plan; (3) the final return/report filed for the plan;
- (2) an amended return/report; (4) a short plan year return/report (less than 12 months).
- C If the plan is a collectively-bargained plan, check here
- D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions)

Part II Basic Plan Information - enter all requested information.

1a Name of plan

MATRIX EMPLOYEE LEASING INC
MINI-MED PLAN



1b Three-digit plan number (PN) ▶

1c Effective date of plan

06 17 2007

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 if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶

Type or print name of individual signing as plan administrator

Date 09 11 2008

a JAMES W MARSHALL

Signature of employer/plan sponsor/DFE

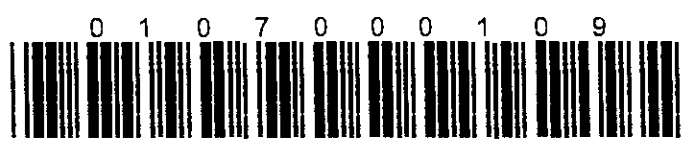
SIGN HERE ▶

Type or print name of individual signing as employer, plan sponsor or DFE

Date 09 11 2008

b WILLIAM L PEREZ

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13500F Form 5500 (2007)



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

1) MATRIX EMPLOYEE LEASING INC

2) C I O

3) 9016 PHILIPS HWY

4) JACKSONVILLE

5) FL 32256

2c Sponsor's telephone
number

2b Employer Identification Number (EIN)

59 3610674

904 739 2722

2d Business code
(see instructions)

561410

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

1) SAME

2) C I O

3)

4)

3b Administrator's EIN

5)

6)

3c Administrator's telephone number

7)

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 below:

a Sponsor's name

b EIN

c PN

0 1 0 7 0 0 0 2 0 A



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

226

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

99

b Retired or separated participants receiving benefits

0

c Other retired or separated participants entitled to future benefits

0

d Subtotal. Add lines 7a, 7b, and 7c

99

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

0

f Total. Add lines 7d and 7e

99

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

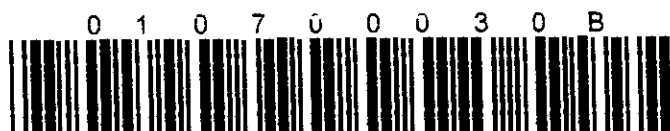
0

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

0

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

0



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

- a Pension benefits** (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):
- b Welfare benefits** (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4A 4B 4D 4E 4F

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

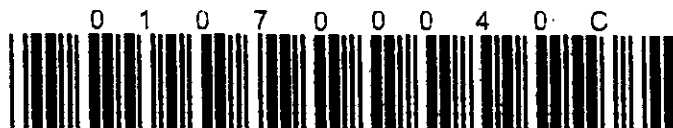
- (1) ☒ Insurance
- (2) Code section 412(i) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)**a Pension Benefit Schedules**

- 1) R (Retirement Plan Information)
- 2) B (Actuarial Information)
- 3) E (ESOP Annual Information)
- 4) SSA (Separated Vested Participant Information)

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information—Small Plan)
- 3) 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.

► **File as an attachment to Form 5500.**

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

Official Use Only

OMB No. 1210-0110

2007

This Form is Open to
Public Inspection.

For calendar plan year 2007 or fiscal plan year beginning 06/17/2007 and ending 06/14/2008

A Name of plan

MATRIX EMPLOYEE LEASING INC. MIDL-MED PLAN

B Three-digit
plan number ►

002

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

MATRIX EMPLOYEE LEASING, Inc

D Employer Identification Number

59-3610674



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:

(a) Name of insurance carrier

RELIANCE STANDARD LIFE INSURANCE COMPANY

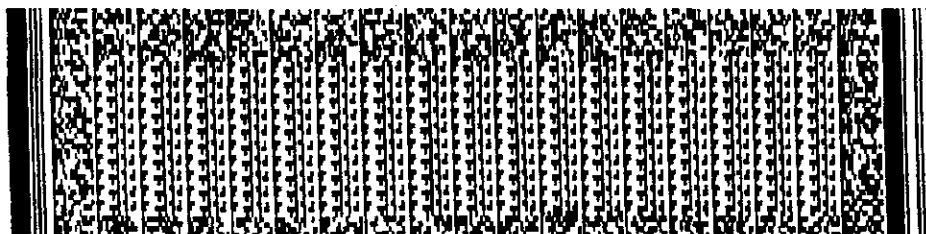
| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|------------------|--|--|-------------------------|------------|
| | | | | (f) From | (g) To |
| 36-0883760 | 68381 | BCM000383 | | 06/17/2007 | 06/14/2008 |

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

| Total amount of commissions paid | Total fees paid / amount |
|----------------------------------|--------------------------|
| 17158 | 0 |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v10.1 Schedule A (Form 5500) 2007



0 6 0 7 5 2 0 1 0 L



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

CRAVEN AND ASSOCIATES
425 N. PALM AVENUE
PALATKA

FL 32177

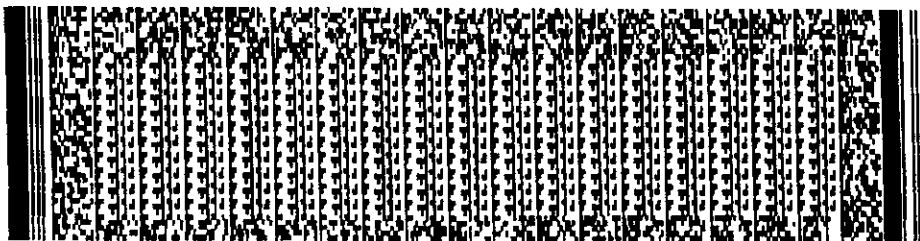
| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|--------------------------------|------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 17158 | 0 | COMMISSIONS | 4 |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|--------------------------------|------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|--------------------------------|------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |



0 6 0 7 5 2 0 2 0 M

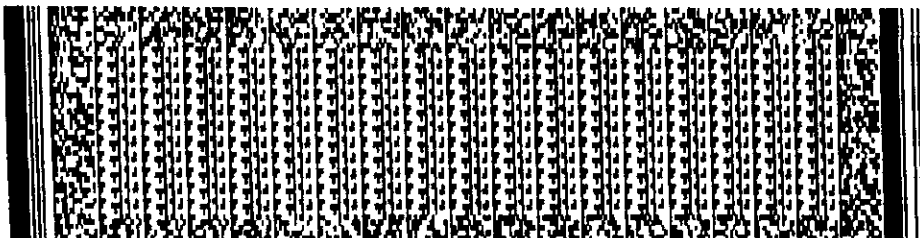


**Welfare Benefit Contract Information**

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

| | | | |
|--|--|---|---|
| 7 Benefit and contract type (check all applicable boxes) | | | |
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input checked="" type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

| | | |
|---|--|--------|
| 8 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) + (2) - (3)) | | 0 |
| b Benefit charges: (1) Claims paid | | |
| (2) Increase (decrease) in claim reserves | | |
| (3) Incurred claims (add (1) and (2)) | | 0 |
| (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 | | 0 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | |
| (2) Claim reserves | | |
| (3) Other reserves | | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) | | |
| 9 Nonexperience-rated contracts: | | |
| a Total premiums or subscription charges paid to carrier | | 171576 |
| 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 | | |
| Specify nature of costs ▶ | | |



0 6 0 7 5 2 0 4 0 0



**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.

► File as an attachment to Form 5500.

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

Official Use Only

OMB No. 1210-0110

2007

This Form is Open to
Public Inspection.

For calendar plan year 2007 or fiscal plan year beginning 06/17/2007 and ending 06/14/2008

A Name of plan

MATRIX EMPLOYEE LEASING INC. MINI MED PLAN

B Three-digit
plan number ►

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

MATRIX EMPLOYEE LEASING INC.

D Employer Identification Number

59-3610674

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:

(a) Name of insurance carrier

RELIANCE STANDARD LIFE INSURANCE COMPANY

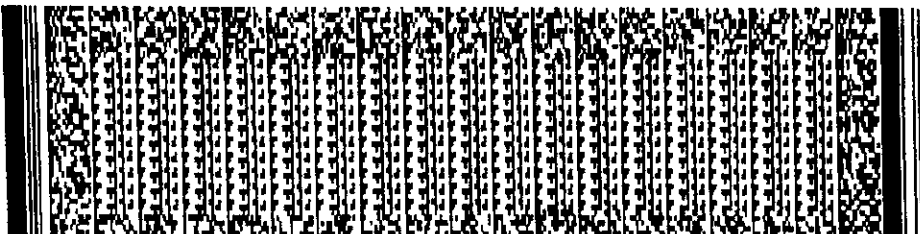
| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|------------------|--|--|-------------------------|------------|
| | | | | (f) From | (g) To |
| 36-0883760 | 68381 | BCM000384 | | 06/17/2007 | 06/14/2008 |

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents,
brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

| Total amount of commissions paid | Total fees paid / amount |
|----------------------------------|--------------------------|
| 4227 | 0 |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v10.1 Schedule A (Form 5500) 2007



0 6 0 7 5 2 0 1 0 L



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

CRAVEN AND ASSOCIATES
425 N. PALM AVENUE
PALATKA

FL 32177

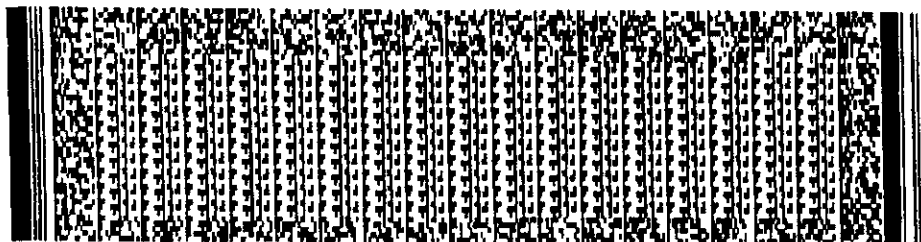
| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 4227 | 0 | COMMISSIONS | 4 |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |



0 6 0 7 5 2 0 2 0 M

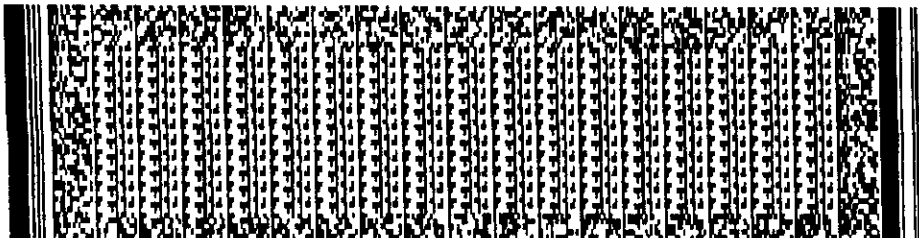


Welfare Benefit Contract Information

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

| | | | |
|--|--|---|---|
| 7 Benefit and contract type (check all applicable boxes) | | | |
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life Insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input checked="" type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

| | | |
|---|--|-------|
| 8 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) + (2) - (3)) | | 0 |
| b Benefit charges: (1) Claims paid | | |
| (2) Increase (decrease) in claim reserves | | |
| (3) Incurred claims (add (1) and (2)) | | 0 |
| (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 | | 0 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | |
| (2) Claim reserves | | |
| (3) Other reserves | | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) | | |
| 9 Nonexperience-rated contracts: | | |
| a Total premiums or subscription charges paid to carrier | | 42269 |
| 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 | | |
| Specify nature of costs ▶ | | |



**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.

► File as an attachment to Form 5500.

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

Official Use Only

OMB No. 1210-0110

2007

This Form is Open to Public Inspection.

For calendar plan year 2007 or fiscal plan year beginning 06/17/2007 and ending 06/14/2008

A Name of plan

MATRIX EMPLOYEE LEASING INC. MINI MED PLAN

B Three-digit plan number ►

002

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

MATRIX EMPLOYEE LEASING INC.

D Employer Identification Number

59-3610674



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:

(a) Name of insurance carrier

RELIANCE STANDARD LIFE INSURANCE COMPANY

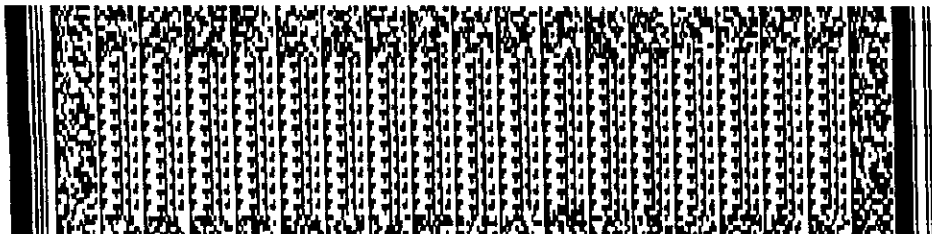
| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 36-0883760 | 68381 | BCD000385 | | 06/17/2007 | 06/14/2008 |

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

| Total amount of commissions paid | Total fees paid / amount |
|----------------------------------|--------------------------|
| 3983 | 0 |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v10.1 Schedule A (Form 5500) 2007



0 6 0 7 5 2 0 1 0 L



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

CRAVEN AND ASSOCIATES
425 N. PALM AVENUE
PALATKA

FL 32177

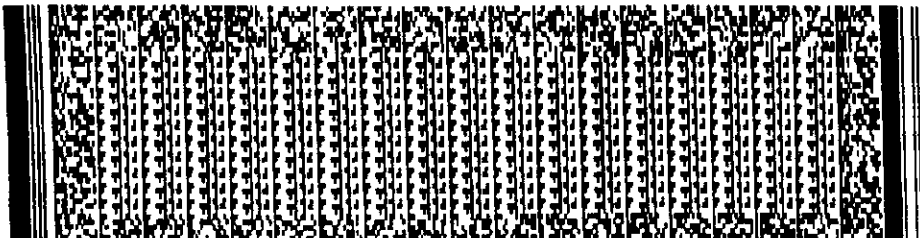
| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 3983 | 0 | COMMISSIONS | 4 |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |



0 6 0 7 5 2 0 2 0 M

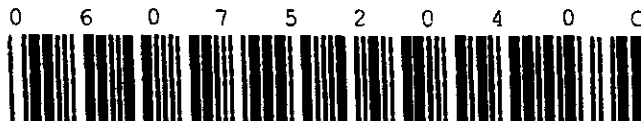
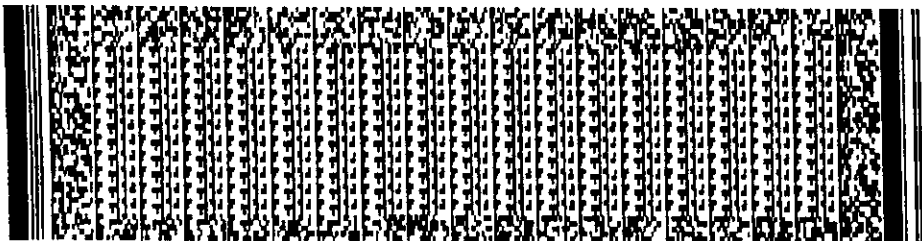


**Welfare Benefit Contract Information**

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

| | | | |
|--|--|---|--|
| 7 Benefit and contract type (check all applicable boxes) | | | |
| a <input type="checkbox"/> Health (other than dental or vision) | b <input checked="" type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life Insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

| | | |
|---|--|-------|
| 8 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) + (2) - (3)) | | 0 |
| b Benefit charges: (1) Claims paid | | |
| (2) Increase (decrease) in claim reserves | | |
| (3) Incurred claims (add (1) and (2)) | | 0 |
| (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 | | 0 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | |
| (2) Claim reserves | | |
| (3) Other reserves | | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) | | |
| 9 Nonexperience-rated contracts: | | |
| a Total premiums or subscription charges paid to carrier | | 39826 |
| 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 | | |
| Specify nature of costs ▶ | | |



**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.

► File as an attachment to Form 5500.

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

Official Use Only

OMB No. 1210-0110

2007

This Form is Open to
Public Inspection.

For calendar plan year 2007 or fiscal plan year beginning 06/17/2007 and ending 06/14/2008

A Name of plan

MATRIX EMPLOYEE LEASING INC MINIMA PLAN

B Three-digit
plan number ►

002

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

MATRIX EMPLOYEE LEASING INC

D Employer Identification Number

59-3610674



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:

(a) Name of insurance carrier

RELIANCE STANDARD 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 |
| 36-0883760 | 68381 | BCL000386 | | 06/17/2007 | 06/14/2008 |

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

| Total amount of commissions paid | Total fees paid / amount |
|----------------------------------|--------------------------|
| 526 | 0 |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v10.1 Schedule A (Form 5500) 2007



0 6 0 7 5 2 0 1 0 L



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

CRAVEN AND ASSOCIATES
425 N. PALM AVENUE
PALATKA

FL 32177

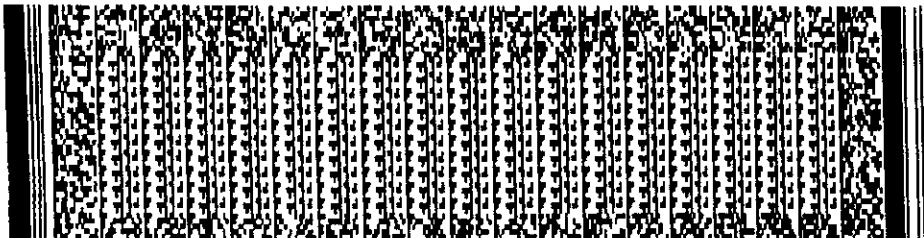
| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 526 | 0 | COMMISSIONS | 4 |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |



0 6 0 7 5 2 0 2 0 M

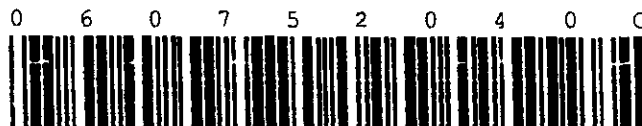
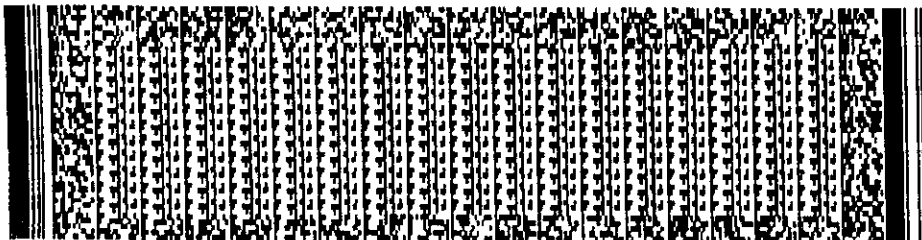


Part III Welfare Benefit Contract Information

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

| | | | |
|--|--|---|---|
| 7 Benefit and contract type (check all applicable boxes) | | | |
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input checked="" type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

| | | |
|---|--|------|
| 8 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) + (2) - (3)) | | |
| b Benefit charges: (1) Claims paid | | 0 |
| (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. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 0 |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | |
| (2) Claim reserves | | |
| (3) Other reserves | | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) | | |
| 9 Nonexperience-rated contracts: | | |
| a Total premiums or subscription charges paid to carrier | | 5259 |
| 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 | | |
| Specify nature of costs ▶ | | |



**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.

► File as an attachment to Form 5500.

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

Official Use Only

OMB No. 1210-0110

2007

This Form is Open to
Public Inspection.

For calendar plan year 2007 or fiscal plan year beginning 06/17/2007 and ending 06/14/2008

A Name of plan

MATRIX EMPLOYEE LEASING INC. MINI-MED PLAN

B Three-digit
plan number ►

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

MATRIX EMPLOYEE LEASING, INC.

D Employer Identification Number

59-3610674



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:

(a) Name of insurance carrier

RELIANCE STANDARD LIFE INSURANCE COMPANY

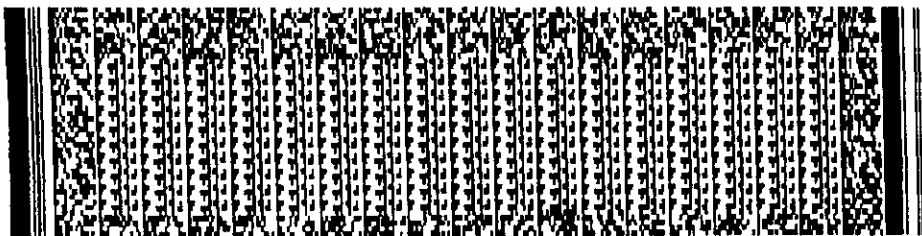
| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|------------------|--|--|-------------------------|------------|
| | | | | (f) From | (g) To |
| 36-0883760 | 68381 | BCS000386 | | 06/17/2007 | 06/14/2008 |

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

| Total amount of commissions paid | Total fees paid / amount |
|----------------------------------|--------------------------|
| 1149 | 0 |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v10.1 Schedule A (Form 5500) 2007



0 6 0 7 5 2 0 1 0 L



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

CRAVEN AND ASSOCIATES
425 N. PALM AVENUE
PALATKA

FL 32177

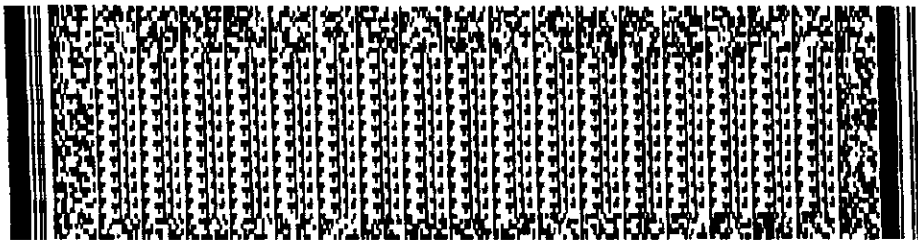
| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 1149 | 0 | COMMISSIONS | 4 |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |

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

| (b) Amount of commissions paid | Fees paid | | (e) Organization code |
|-----------------------------------|------------|-------------|-----------------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 0 | | |



0 6 0 7 5 2 0 2 0 M



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

7 Benefit and contract type (check all applicable boxes)

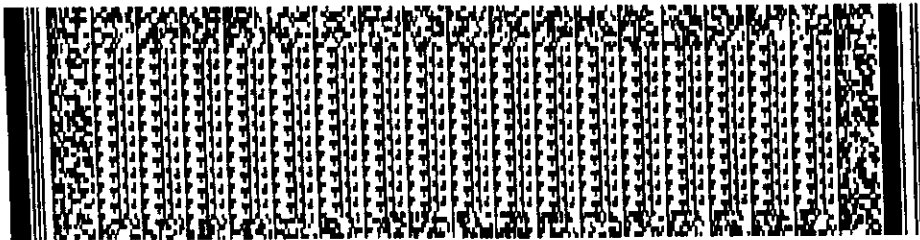
- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☒ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO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

8 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) + (2) - (3)) 0
b Benefit charges: (1) Claims paid
 (2) Increase (decrease) in claim reserves
 (3) Incurred claims (add (1) and (2)) 0
 (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 0
 (2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement
 (2) Claim reserves
 (3) Other reserves
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

- a** Total premiums or subscription charges paid to carrier 11487
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
 Specify nature of costs ►



0 6 0 7 5 2 0 4 0 0

