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 06/17/2007 and ending 06/17/2008

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:
- [X] 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
MATRIX EMP LEASING INC MINI-MED PLAN

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 PHILIPS HWY
JACKSONVILLE, FL 32256

9016 PHILIPS HWY
JACKSONVILLE, FL 32256

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 PHILIPS 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)

- **(1)** ☐ 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)** ☐ 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)** ☐ ___ **A** (Insurance Information)
- **(4)** ☐ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

59-3610674P

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

Form 5500 Annual Return/Report of Employee Benefit Plan

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

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.**

2007 200806

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

RECEIVED
AUG 23 2010
OGDEN, UT

1b Three-digit plan number (PN) ▶ 501

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 ▶ Date 09 11 2008

Type or print name of individual signing as plan administrator

a JAMES W MARSHALL

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Date 09 11 2008

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

b WILLIAM L PEREZ

0 1 0 7 0 0 0 1 0 9

v10.1

NOV 29 2011

Official Use Only

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/O

3) 9016 PHILIPS HWY

4) JACKSONVILLE

5) FL 32256

6)

7)

8)

9)

2b Employer Identification Number (EIN) 59 3610674

2c Sponsor's telephone number 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/O

3)

4)

5)

6)

7)

3b Administrator's EIN

3c Administrator's telephone number

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

Official Use Only

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

0 1 0 7 0 0 0 3 0 B

Official Use Only

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**		b **Financial Schedules**	
1)	**R** (Retirement Plan Information)	1)	**H** (Financial Information)
2)	**B** (Actuarial Information)	2)	**I** (Financial Information–Small Plan)
3)	**E** (ESOP Annual Information)	3)	**A** (Insurance Information)
4)	**SSA** (Separated Vested Participant Information)	4)	**C** (Service Provider Information)
		5)	**D** (DFE/Participating Plan Information)
		6)	**G** (Financial Transaction Schedules)

0 1 0 7 0 0 0 4 0 C

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. MIDI-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

Part II 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

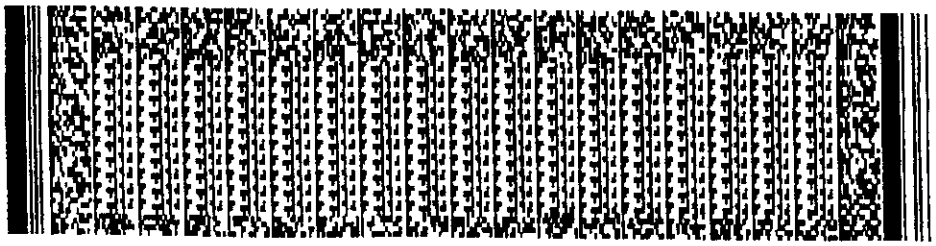
RELIANCE STANDARD LIFE INSURANCE COMPANY

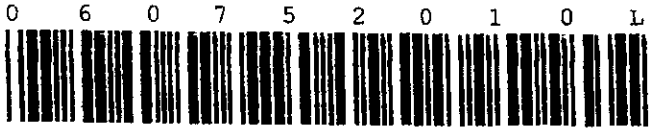
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
36-0883760	68381	BCM000383		06/17/2007	06/14/2008

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





Official Use Only

(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

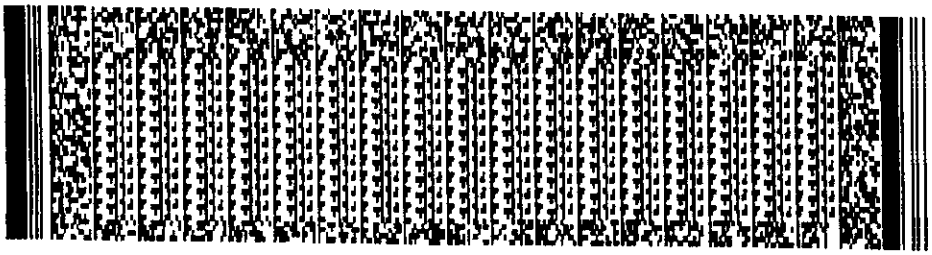
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
17158	0	COMMISSIONS	4

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

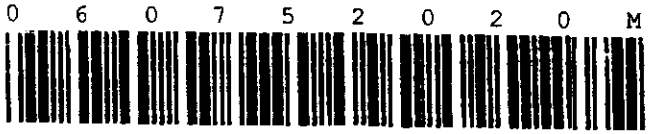
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	0		

(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



Official Use Only

Part II 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		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. MIN. 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

Part II 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

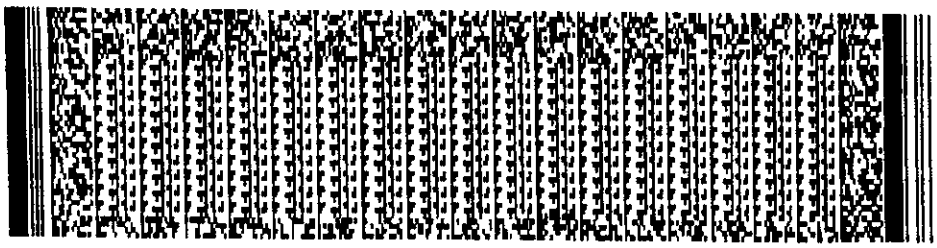
RELIANCE STANDARD LIFE INSURANCE COMPANY

(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

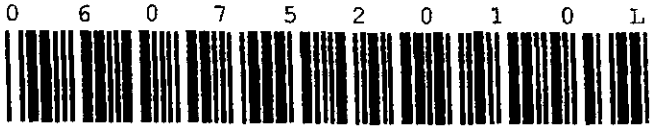
2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

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



0 6 0 7 5 2 0 1 0 L



Official Use Only

(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

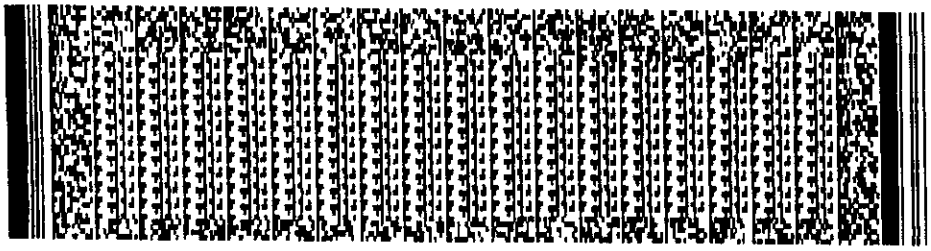
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
4227	0	COMMISSIONS	4

(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

Official Use Only

Part II Welfare Benefit Contract Information

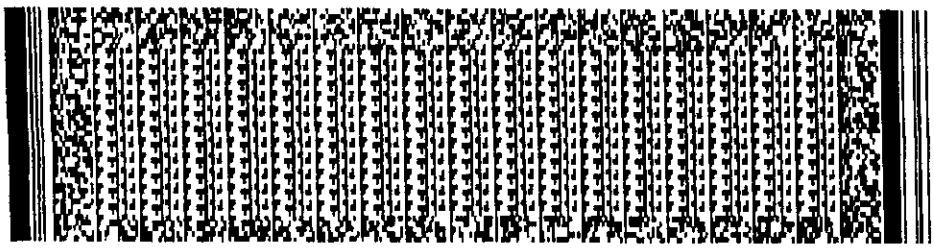
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such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

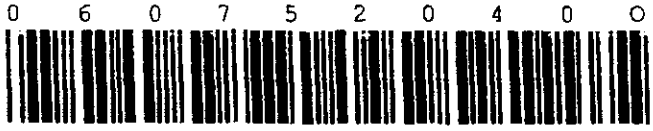
a ☐ Health (other than dental or vision)	b ☐ Dental	c ☐ Vision	d ☐ Life Insurance
e ☐ Temporary disability (accident and sickness)	f ☐ Long-term disability	g ☐ Supplemental unemployment	h ☐ Prescription drug
i ☐ Stop loss (large deductible)	j ☐ HMO contract	k ☐ PPO contract	l ☒ Indemnity contract
m ☐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

8	Experience-rated contracts		
a	Premiums: (1) Amount received		
	(2) Increase (decrasse) 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		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 ▶



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 ▶: 002
C Plan sponsor's name as shown on line 2a of Form 5500: MATRIX EMPLOYEE LEASING INC.
D Employer Identification Number: 59-3610674

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:

(a) Name of insurance carrier

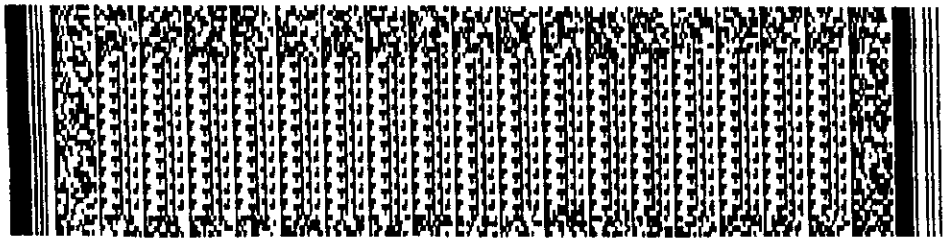
RELIANCE STANDARD LIFE INSURANCE COMPANY

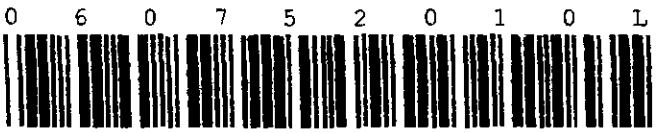
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
36-0883760	68381	BCD000385		06/17/2007	06/14/2008

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





Official Use Only

(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

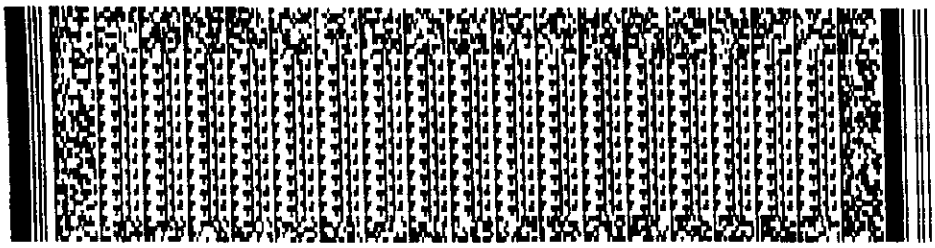
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
3983	0	COMMISSIONS	4

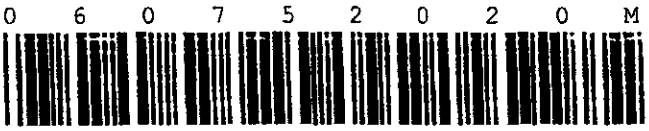
(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(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		





Official Use Only

Part II 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 retantion		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		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 ▶

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 ▶: 002

C Plan sponsor's name as shown on line 2a of Form 5500: MATRIX EMPLOYEE LEASING INC

D Employer Identification Number: 59-3610674

Part II 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

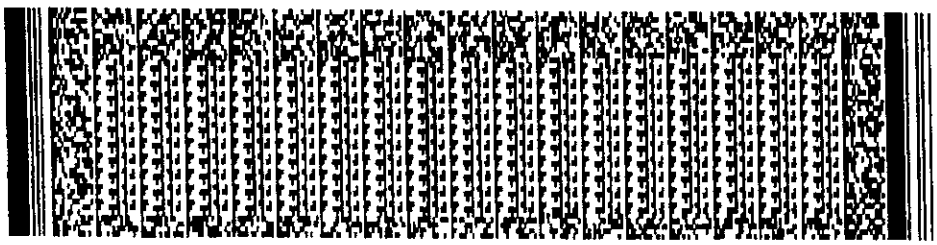
RELIANCE STANDARD LIFE INSURANCE COMPANY

(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

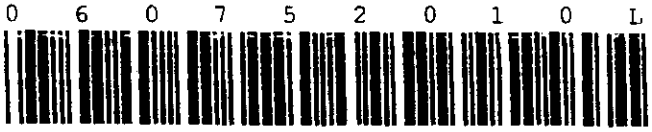
2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

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



0 6 0 7 5 2 0 1 0 L



Official Use Only

(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

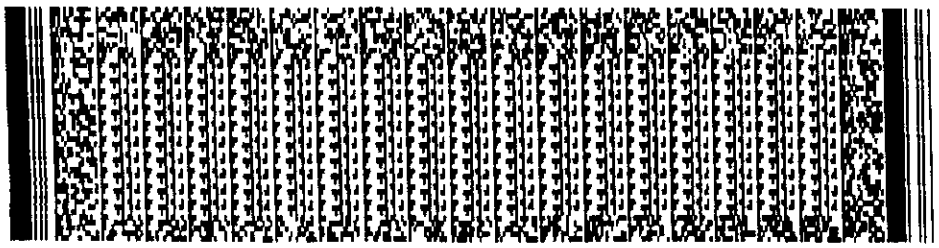
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
526	0	COMMISSIONS	4

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

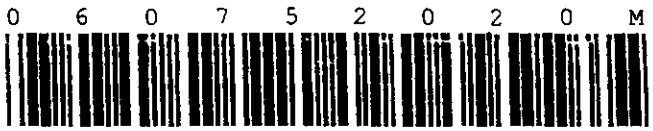
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	0		

(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



Official Use Only

Part II 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		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 ▶

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: 59-3410674

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:

(a) Name of insurance carrier

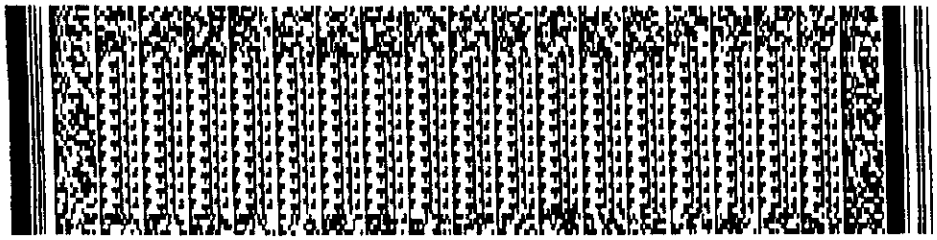
RELIANCE STANDARD LIFE INSURANCE COMPANY

(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



0 6 0 7 5 2 0 1 0 L

Official Use Only

(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

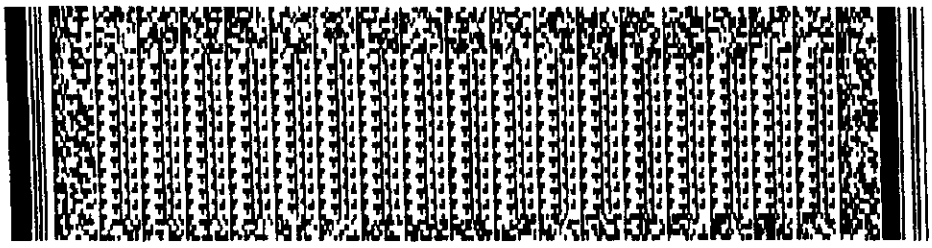
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
1149	0	COMMISSIONS	4

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

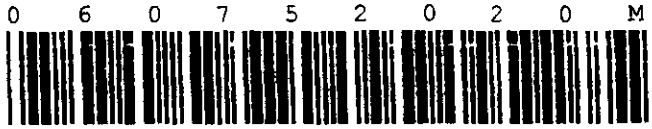
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	0		

(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



Official Use Only

Part III Welfare Benefit Contract Information

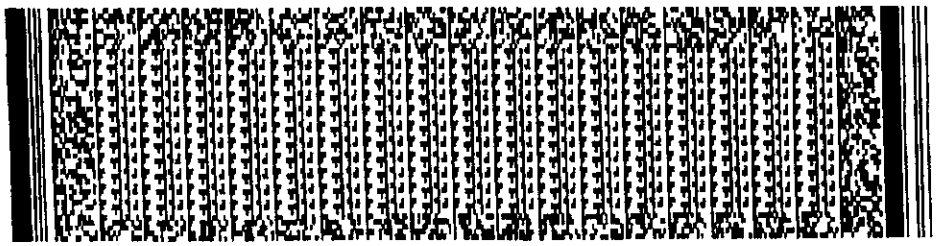
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such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