Form 5500	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service	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).	2009
Department of Labor Employee Benefits Security Administration	Complete all entries in accordance with the instructions to the Form 5500.	
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection
Part I Annual Report Ider	tification Information	
For calendar plan year 2009 or fiscal	plan year beginning 06/17/2007 and ending 06/17/2	2008
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or	
·	a single-employer plan; a DFE (specify)	
B This return/report is:	the first return/report; the final return/report;	
·	an amended return/report; a short plan year return/report (less t	han 12 months).
\mathbf{C} If the plan is a collectively-bargain	ed plan, check here.	
D Check box if filing under:	Form 5558; automatic extension;	the DFVC program;
	special extension (enter description)	
Part II Basic Plan Inform	nation—enter all requested information	
1a Name of plan MATRIX EMP LEASING INC MINI-M		1b Three-digit plan number (PN) → 002
		1c Effective date of plan 06/17/2007
2a Plan sponsor's name and addres (Address should include room or s MATRIX EMPLOYEE LEASING INC	s (employer, if for a single-employer plan) suite no.)	2b Employer Identification Number (EIN) 59-3610674
		2c Sponsor's telephone number 904-739-2722
9016 PHILIPS HWY JACKSONVILLE, FL 32256	9016 PHILIPS HWY JACKSONVILLE, FL 32256	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			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

	Plan administrator's name and address (if same as plan sponsor, enter "Same") TRIX EMPLOYEE LEASING INC		ministrator's EIN 3610674
	16 PHILIPS HWY CKSONVILLE, FL 32256	nu	ministrator's telephone mber I-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 the plan number from the last return/report:	and	4b EIN
а	Sponsor's name		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).		
а	Active participants	6a	
b	Retired or separated participants receiving benefits	6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a, 6b, and 6c	6d	
е	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	
	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 fur	nding	arrangement (check all that apply)	9b	Plan bene	efit a	arrangement (check all that apply)
	(1)		Insurance		(1)		Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Trust
	(4)		General assets of the sponsor		(4)		General assets of the sponsor
10	Check a	all ap	plicable boxes in 10a and 10b to indicate which schedules are a	ttache	d, and, wh	nere	e indicated, enter the number attached. (See instructions)
	a Pension Schedules b						
а	Pensio	n Scl	hedules	b	General	Sch	nedules
а	Pensio (1)	n Scl	hedules R (Retirement Plan Information)	b	General (1)	Sch	nedules H (Financial Information)
а		n Scl		b		Sch	
а	(1)	n Scl	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	b	(1)	Sch	H (Financial Information)
а	(1)	n Scl	R (Retirement Plan Information)MB (Multiemployer Defined Benefit Plan and Certain Money	b	(1) (2)	Sch	H (Financial Information)I (Financial Information – Small Plan)
а	(1)		 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	b	(1) (2) (3)	Sch	 H (Financial Information) I (Financial Information – Small Plan) A (Insurance Information)

Page 2

	and an and a second			
	59-36106	747		
5500 Annual R	teturn/Report of Em	nlovee Benefit	Plan	ial Use Only
Department of the Treasury This form is n	equired to be filed under sections	and the state of the		10-0110 / 1210-0089
Internal Revenue Service Retiremen	t-Income Security Act of 1974 (El	RISA) and sections 6047		007
······································	b), and 6058(a) of the Internal Rev Complete all entries in ac		This Fr	
Pension Benefit Guaranty Corporation	the instructions to the			Inspection.
Part I Annual Report identificati	on information		(
For the calendar plan year 2007 / O or fiscal plan year beginning	6 17 2007	and ending	06 14	2008
A This return/report is for: (1) a r	nultiemployer plan;	(3) a multiple-	employer plan; or	
	single-employer plan (other than nultiple-employer plan);	(4) a DFE (sp	pecify)	
B This return/report is: (1) the	e first return/report filed for the plan;	(3) the final r	eturn/report filed for the	plan;
(2) an	amended return/report;		an year return/report 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 alta	ch required information. (s	see Instructions)	►
Part II Basic Plan Information	enter all requested information	on.		
1a Name of plan	and the second second		\backslash	
MATRIX EMP	LOYFE LEA	SING I	Ne RE	
MINI-MED F	LAN			2 3 2010
\mathbf{X}			OG	DEN, UT
	$\left A \right $	AND		
1b Three-digit-plan number (PN)►	10	Effective date of plan	06 17	2007
Caution: A penalty for the late or incomple				
Under penalties of perjury and other penalties schedules, statements and attachments, as we knowledge and belief, it is true, corract and Signature of plan administrator,	ties set forth in the instructions, i de well as the electropic version of this complete	clare that I have examined return/report if it is being	a this return/report, inclu g filed electronically, and	ang accompanying I to the best of my
SIGN HERE	all le	Date	09 11	2008
Type or print name of individual signing as p				
a JAMES/WM,	RSHALL			
Signature of employer/plan sponsor/DFE	20		09 11	TOOR
SIGN HERE Type or print name of individuel signing as		Date	$\rho \gamma \gamma \gamma$	2000
b WILLIAM L	PEREZ			
For Paperwork Reduction Act Notice and	•	nstructions for Form 550	0. Cat. No. 13500F	Form 5500 (2007)
			v10.1	
\mathbf{v}				

· F		
I	Forth: 5500 (2007)	age 2
		Official Use Only
2a	Plan sponsor's name and address (employer, if for single-employer plan) (Address should include	\mathbf{X}
1)	MATRIX EMPLOYEE LEASING	INC
(2)	с / о	
1 ·	9016 PHILIPS HUY	
4)	JACKSONVILLE	26 Employer Identification Number (EIN)
5)	FL 32256	59 3610674
6)	2c Sponsor's telephone number / 9	04 139 Z7ZZ
7)	20	Business code see instructions) 561410
8)	The second	and the second se
-,	and the second se	and a restricted whether
3a	Plan administrator's name and address (If same as plan sponsor, enter "Same")	
1)	SAME	· · · .
2)	c / o	
3)		
4)	36	Administrator's EIN
		·
6)	30	Administrator's telephone number
7)		
4 a	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for the number from the last return/report below: Sponsor's name	s plan, enter the name, EIN and the plan

b EIN

c PN



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ł	Form 6500 (2007)	Page 3	Official Use Only
1	Preparer information (optional)		
ຊີ	Name (including firm name, if applicable) and address		
1)			
2)			
3)		b EIN	
4)			
5)		c Telephone num	iber
		•••••••	
6)			
_			ZZ6
6	Total number of participants at the beginning of the plan year		6 6 10
7	Number of participants as of the end of the plan year (welfare plans complete only lines 7	7a 7b 7c. and 7d)	
			00
a	Active participants		99
			C
b	Retired or separated participants receiving benefits		0
~	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 benefit	IS	٥
	f Total. Add lines 7d and 7e		99
	Number of participants with account balances as of the end of the plan year (only define	d	
1	contribution plans complete this item)		Ø
I	Number of participants that terminated employment during the plan year with accrued be	enefits that	-
	were less than 100% vested		0
	i If any participant(s) separated from service with a deferred vested benefit, enter the num		r.
	separated perticipants required to be reported on a Schedule SSA (Form 5500)		0



	· ·	1	
. 1			
	Form 5500 (2007)	Page 4	
	x		Official Use Only
8	Benefits provided under the plan (complete 8a and 8b, as applicable)		

	periones broaded r	foouthiere of	a anu ov, as	appilicable)
•				

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 tha instructions):

4A 4B 4D 4E 4F

9a	Plan funding	g arrangement (check all that apply)	9b	Plan	benei	it arrangement (chack all that apply)
	(1)	irisurance		(1)	/	Insurance
	(2)	Code section 412(i) insurance contracts		(2)		Code section 412(i) insurance contracts
	(3)	Trust		(3)		Trust
	(4)	General assets of the sponsor		(4)		General assets of the sponsor

10 Schedules attached (Chack all applicable boxes and, where indicated, enter the number attached. See instructions.)

á	Pension Benefit Schedules		b Financial Schedules	
	1)	R (Retirement Plan Information)	1)	H (Financial Information)
	2)	B (Actuarial Information)	2)	I (Financial InformationSmall Plan)
	3)	E (ESOP Annual Information)	3)	A (Insurance Information)
	4)	SSA (Separated Vested Participant Information)	4)	C (Sarvice Provider Information)
			5)	D (DFE/Participating Plan Information)

6)

G (Financial Transaction Schedules)



A Name of plan MATRIX C Plan sponsor's r MATRIX Partin Infor Provio	5500) The Treasury anus Service to Labor scurky Administrat aranty Corporation par 2007 or fis minutes y set hame as show Employ rmation Co de Information	This schedule Employed Fill Inn Fill Insurance com Cal plan year beginning Cal plan year beginn year beginning Cal plan year beginning Cal plan year b	is required to b e Retirement inc e as an attachr npanies are requirsuant to ERIS, 06/17/2007 Midi - J Tud C ontract Cove	Mai PLAN rage, Fees, and Cor	ation ng 06/ B Three-C plan nu D Employ 59- nmissions	OME This I Pub 14/2008 ligit mber ► ver IdentIfic 36/06	
1 Coverage:	ed on a single		ame of insuranc	e carrier			
RELIANCE STA	(C) NAIC	FE INSURANCE COMPA	(e) Appro	ximate number of persons			contract year
36-0883760	68381	BCM000383			06/1	7/2007	(g) To 06/14/2008
2 insurance fee brokers and c	es and commis other persons	ssions paid to agents, brokers individually in descending orde	r of the amount	ns. Enter the total fees and paid in the items on the fo	l total comm llowing page	issions belo (s) in Part I,	w and list agents,
· · · · · · · · · · · · · · · · · · ·	Total amount	of commissions paid	Totals	Tota	fees paid /	amount	
			17158				0
For Paperwork Re	duction Act I	Notice and OMB Control Num	nbers, see the i	nstructions for Form 55(10. v10.1	Schedule	A (Form 5500) 200

	07 · · · · · · · · · · · · · · · · · · ·	Page 2	Official Use Only	
	(a) Name and addre persons to whom	ss of the agents, brokers or other commissions or fees were paid		
CRAVEN AND ASSOCIATES 425 N. PALM AVENUE PALATKA	FL 32177			
(b) Amount of		(e)		
commissions paid	(c) Amount	(c) Amount (d) Purpose		
17158	0 (COI	0 COMMISSIONS		
	(a) Name and addre	ess of the agents, brokers or other commissions or fees were paid		

(b) Amount of	Fees paid			
commissions paid	(c) Amount	(d) Purpose	Organization code	
0	0			
	(a) Name and address	of the agents, brokers or other mmissions or fees were paid		

(b) Amount of commissions paid			(e) Organization	
		(c) Amount	(d) Purpose	code
<u></u>	0	0		



a e i m E: a P (;	Welfare Benefit Contract Inform If more than one contract covers the sam employee organization(s), the information as a unit. Where individual contracts are treated as a unit for purposes on this rep mefit and contract type (check all applicable box Health (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify) ► coerience-rated contracts remiums: (1) Amount received	e group of employees of the n may be combined for report provided, the entire group of ort. es) b Dental	ling purposes if such contracts are i	d Life insurance
a e i m E a P (Heaith (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify) ► sperience-rated contracts	b Dental f Long-term disability	g Supplemental unemployme	ant h Prescription drug
a Pi (:	•			I X Indemnity contra
¢				
	2) Increase (decrease) in amount due but unpaid			
	 B) Increase (decrease) in uneamed premium reset 			
	4) Earned ((1) + (2) - (3))			
	enefit charges: (1) Claims paid			an eine mit ihr an eine beiten b
	2) Increase (decrease) in claim reserves			
	3) Incurred claims (add (1) and (2))			
(4) Claims charged			
	emainder of premlum: (1) Retention charges (on			in the second
	(A) Commissions			
	(B) Administrative service or other fees			
	(C) Other specific acquisition costs			
	(D) Other expenses			
	(E) Taxes			Hammer one has a started by
	(F) Charges for risks or other contingencies .			
	(G) Other retention charges			
	(H) Total retention	••••••••••••••••••••••••••••••••••••••	· · · · · · · · · · · · · · · · · · ·	
. (Dividends or retroactive rate refunds. (These a	mounts were paid in cash	, orcredited.)	
ds	tatus of policyholder reserves at end of year: (1)	Amount held to provide bene	efits after retirement	
(2) Claim reserves			
	3) Other reserves.			
<u>e [</u> N	ividends or retroactive rate refunds due. (Do not	include amount entered in c(2).)	
	lonexperience-rated contracts:			
a 1 L	otal premiums or subscription charges paid to ca	nrier		1715
b h	the carrier, service, or other organization incurre	d any specific costs in conne	ction with the acquisition	
	r retention of the contract or policy, ether than re-	perted in Part 1, item 2 above	, report amount	······





SCHEDULE A	L	fficial Use Only			
(Form 5500)	1	is required to be filed und		r i	No. 1210-0110
Department of the Treasury	1	Retirement Income Seci			
Internal Revenue Service	🕨 File	as an attachment to Fe	orm 5500.		2007
Employee Benefits Security Administration	Insurance com	panies are required to pr	ovide this information	This f	orm is Open to
Pension Benefit Guaranty Corporation		suant to ERISA section	103(a)(2).		lic inspection.
For calendar plan year 2007 or fiscal pla	an year beginning 0	6/17/2007	and ending	06/14/2008	······
A Name of plan MATRIX EMPLOYEE	EASING THE	Midi MED	PLAN B	Three-digit plan number 🕨	
C Plan sponsor's name as shown on I MMRIX Employee Information Concer	LEASING IN	de.		Employer Identific	
Provide information for ea reported on a single Sche 1 Coverage:	adule A.		contracts grouped as	a unit in Parts II and	l III can be
RELIANCE STANDARD LIFE		ame of insurance camer			
(b) EIN (c) NAIC	(d) Contract or	(e) Approximate nu	mber of persons	Policy or c	ontract year
(D) EIN code	identification number	covered at end of poli	cy or contract year	(f) From	(g) To
	1000384			06/17/2007	06/14/2008
2 Insurance fees and commissions brokers and other persons individ	paid to agents, brokers a lually in descending order	of the amount paid in the	the total fees and tota e items on the following	I commissions belowing page(s) in Part I.	w and list agents,
		Totals			
Total amount of col	mmissions paid	}	Total fee	s paid / amount	

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4227 0 For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v10.1 Schedule A (Form 5500) 2007

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Schedule A (Form 5500) 20		Page 2	Official Use Only	
		of the agents, brokers or other mmissions or fees were paid		
CRAVEN AND ASSOCIATES 425 N. PALM AVENUE PALATKA	FL 32177			
(b) Amount of		(e) Organization		
commissions paid	(c) Amount	nount (d) Purpose		
4227	0 COMM	ISSIONS	4	
		of the agents, brokers or other mmissions or fees were paid		

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



	Schedule A (Form 5500) 2007	Page 4	Official Use Only
	Welfare Benefit Contract Information		
	If more than one contract covers the same group of employees of the sa	ame employer(s) or members of the	same
	employee organization(s), the information may be combined for reporting	g purposes if such contracts are ex	perience-rated
	as a unit. Where individual contracts are provided, the entire group of su	ch individual contracts with each c	arrier may be
	treated as a unit for purposes on this report.		
В	enefit and contract type (check all applicable boxes)	-	-
а		c Vision	d Life Insurance
е		g Supplemental unemployment	
i	Stop loss (large deductible) j HMO contract	k 📙 PPO contract	 I X indemnity contract
m	Other (specify) >	·	_
E	xperience-rated contracts		
a P	remiums: (1) Amount received		
(2) Increase (decrasse) in amount due but unpaid		
(3) Increase (decrease) in uneamed premium reserve		
(4) Eamed ((1) + (2) - (3))		
bε	enefit charges: (1) Claims paid		
1	2) increese (decrease) in claim reserves		
1	3) Incurred claims (add (1) and (2))		
	4) Cialms charged		
C F	Remainder of premium: (1) Retention charges (on an accrual basis)		
	(A) Commissions	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	(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		the art of a light grant for an art of a
	(H) Total retention	· · · · · · · · · · · · · · · · · · ·	
	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, (or Credited.)	
	Status of policyholder reserves et end of year: (1) Amount held to provide benefit		
	(2) Claim reserves.		······································
	(3) Other reserves.	· · · · · · · · · · · · · · · · · · ·	
е	Dividends or retroective rate refunds due. (Do not include amount entered in c(2)		
	Nonexperience-rated contracts:		
	Total premiums or subscription charges paid to carrier	han the second se	422
	If the camer, service, or other organization incurred any specific costs in connec		
	or retention of the contract or policy, other than reported in Part I, item 2 above	· · · ·	





SCHEDULE A (Form 5500) Insurance information Department of the Treasury Internal Revenue Service This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974. Department of Labor File as an attachment to Form 5500. Department of Labor Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2). For calendar plan year 2007 or fiscal plan year beginning 06/17/2007 and ending 06/1 A Name of plan Markix Employee Labor Twc. Min Math B Three-dig pian numition					OME This Pub 06/14/2008 Three-digit	Hidal Use Only No. 1210-0110 2007 Form is Open to lic Inspection.
MATRIX	Enpeo	n on line 2a of Form 5500	Ide.	D	Employer Identific 59-3610	
	de information ted on a single		e Schedule A. Individua		a unit in Parts II an	d III can be
	ANDARD LI	FE INSURANCE COMPA	ŊУ	umber of persons	Policy or	contract year
(b) EIN	code	identification number		olicy or contract year	(f) From	(g) To
36-0883760		BCD000385			06/17/2007	06/14/2008
		sions paid to agents, brokers a individually in descending orde	r of the amount paid in t			
	Totol one unit	of an inclusion and	Totals			
	TOTAL SMOUNT	of commissions paid	3983		s paid / amount	
For Paperwork Re	duction Act I	Notice and OMB Control Num		ions for Form 5500.	v10.1 Schedule	A (Form 5500) 20



х х					
Schedule A (Form 5500) 2007	 	 	Page 2	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		Fees paid		
commissions paid	(c) Amount	(d) Purpose	code	
3983 -		MISSIONS	4	
		ess of the agents, brokers or other commissions or fees were paid		

(b) Amount of		Fees paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
0	0		
		address of the agents, brokers or other hom commissions or fees were paid	

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



	Schedule A (Form 5500) 2007 Page 4	Official Use Only
1990	Welfare Benefit Contract information If more than one contract covers the same group of employees of the same employer(s) or members o employee organization(s), the Information may be combined for reporting purposes if such contracts ar as a unit. Where individual contracts are provided, the entire group of such individual contracts with ear treated as a unit for purposes on this report.	f the same e experience-rated
e	Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b X Dental C Vision a Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployr i Stop loss (large deductible) j HMO contract k PPO contract	d Life Insurance nent h Prescription drug I Indemnity contract
8	Experience-rated contracts	
а	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 (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2)) (4) Claims charged	
С	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 (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or predited.)	
d e	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves. Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)	
9	Nonexperience-rated contracts:	
a b	Total premiums or subscription charges paid to carrier	





A Name of plan MATRIX EARLOY OF LEASING INC MINIMA PM B Three-dig plan num C Plan sponsor's name as shown on line 2a of Form 5500 D Employee					ber ► 002 r Identification Number			
Provid		for each contract on a separat Schedule A.	te Scheduk			missions	<u>36/0</u> Parts II and	
	NDARD LI	FE INSURANCE COMPA		pproximate num	ber of persons	<u> </u>	Policy or (contract year
(b) EIN	code	identification number		• •	y or contract yaa		From	(g) To
36-0883760 2 insurance fee brokers and c	68381 s and commis ther persons i	BCL000386 sions paid to agents, brokers ndividually in descending orde	and other p er of the arm	ersons. Enter th	e total fees and items on the follo	06/17 otal commis	sions belo	06/14/2008 w and list agents,
				tals				
For Paperwork Re		of commissions paid	526	the instruction		ees paid / ar		() A (Form 5500) 200



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• •	Schedule A (Form 5500) 2007	Page 2	
			 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 321	.77	
(b) Amount of commissions paid	Fees paid		
	(c) Amount	(d) Purpose	code
526	(COMMISSIONS	4
			e din her hendere de
		address of the agents, brokers or other whom commissions or fees were paid	

(b) Amount of commissions paid		Fees paid	(e) Organization
	(c) Amount	(d) Purpose	code
0	0.		
		s of the agents, brokers or other commissions or fees were paid	

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

0 6	52	02	0 M

	chedule A (Form 5500) 2007 Pag		Official Use Only
	Welfare Benefit Contract Information		· · · · · · · · · · · · · · · · · · ·
	If more than one contract covers the same group of employees of the same employer(s) or		
	employee organization(s), the information may be combined for reporting purposes if such		
	as a unit. Where individual contracts are provided, the entire group of such individual contra	acts with each ca	irrier may be
	treated as a unit for purposes on this report.		
Benefit a	and contract type (check all applicable boxes)		_
	alth (other than dental or vision) b Dental C Vision		d X Life Insurance
ê 🗌 Ter		l unempioyment	h Prescription drug
i 🗌 Sto	op loss (large deductible) j 🗌 HMO contract 🛛 k 🗌 PPO contract	ι	I 🔲 Indemnity contrac
m Oth	ner (specify) >		
Experier	nce-rated contracts	53 4 A	
	ms: (1) Amount received	14.11	
(2) Incr	rease (decrease) in amount due but unpaid		The Baseline Courts and
	rease (decrease) in unearned premium reserve		
(4) Ear	ned ((1) + (2) - (3))		
Benefit	cherges: (1) Claims paid		
	rease (decrease) in claim reserves		
	urred claims (add (1) and (2))		
(4) Cla	ims charged		
• •	nder of premium: (1) Retention charges (on an accrual basis)		
	Commissions		
	Administrative service or other fees		
• •	Other specific acquisition costs		
) Other expenses .		n de la constant de l
) Taxes		
) Charges for risks or other contingencies		
) Other ratention charges		
) Total retention		
	ridends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	(married and the second se	
	of policyholder reserves at end of year: (1) Amount hald to provide benefits after retirement .		
	aim reserves		
	her reserves		
	nds or retroactive rate refunds due. (Do not include amount entered in c(2).)		
	perience-rated contracts:	新 能能	
	remiums or subscription charges paid to carrier		52:
	arrier, service, or other organization incurred any specific costs in connection with the acquis		
	ntion of the contract or policy, other than reported in Part I, Item 2 above, report amount		
() if	y-nature-of-costs-		

SCHED		I Ins	surance Infor	mation		Off	icial Use Only
			is required to be filed ur	der section 104 of th	e	OMB	No. 1210-0110
Internal Reve	Department of the Treasury Employee Retirement Income Security Act of 1974.					2007	
Employee Benefits Se	Employee Benefits Security Administration Insurance companies are required to provide this information Pension Benefit Guaranty Corporation pursuant to ERISA section 103(a)(2).				n	This Form is Open to Public Inspection.	
For calendar plan ye	ar 2007 or fisc	al plan year beginning 0	6/17/2007	and ending	06/1	4/2008	
A Name of plan	EMPLOY	EE LEASING	INC. Mini	MED TLAN	Three-dig pian num	ber 🕨	
C Plan sponsor's r		n on tine 2a of Form 5500'	INC.			r Idaniifica	tion Number
	de information and on a single		e Schedule A. Individua	<u> </u>	s a unit in F	Parts II and	III can be
RELIANCE STA	ANDARD LI	FE INSURANCE COMPA	ŊΥ				
(h) Eini	(c) NAIC	(d) Contract or	(e) Approximate n	umber of persons		Policy or c	ontract year
(b) EIN	code	identification number	covered at end of po	nicy or contract year	(f)	From	(g) To
36-0883760	68381	BCS000386			06/17	/2007	06/14/2008
		sions paid to agents, brokers a ndividually in descending orde	-				v and list agents,
			Totals				
	Total amount	of commissions paid		Total fe	es paid / ar	nount	
For Daponwork Bo	duction Act	Notice and OMB Control Num	1149	ions for Eoron ESCO	v10 1	Fabadula	0 A /Eorm 5500\ 200



Schedule A (Form 5500) 20	07	Page 2	Official Use Only
		ess of the agents, brokers or other commissions or fees were paid	
CRAVEN AND ASSOCIATES			
425 N. PALM AVENUE			
PALATKA	<u>FL 32177</u>		
(b) Amount of		Fees paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1149	0100	MMISSIONS	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
	(c) Amount	(d) Purpose	code
0	0		
	.,	the agents, brokers or other nissions or fees were paid	

(b) Amount of commissions paid	Fees paid		(e) Organization
	(c) Amount	(d) Purpose	code
0	0		
0	<u> </u>	······································	



		Page 4	
	Schedule A (Form 5500) 2007		Official Use Only
	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the employee organization(s), the information may be combined for report as a unit. Where individual contracts are provided, the entire group of treated as a unit for purposes on this report.	ng purposes if such contracts are	experience-rated
a ☐ H e ⊠ ⊤ i ☐ s	it and contract type (check all applicable boxes) lealth (other than dental or vision) b Dental remporary disability (accident and sickness) f Long-term disability stop loss (large deductible) j HMO contract Dther (specify) ►	C Vision G Supplemental unemploymental k PPO contract	d 🗌 Life Insurance ent h Prescription drug I IIIIndemnity contract
8 Exper a Premi (2) In (3) In (4) E	rience-rated contracts iums: (1) Amount received		
(2) ir (3) ir (4) C	fit charges: (1) Claims paid		

•

	(2) Increase (decrease) in claim reserves	
	(3) Incurred claims (add (1) and (2))	0
	(4) Claims charged	
¢	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 expanses	
	(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	
е	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)	
9	Nonexperience-rated contracts:	
а	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	1
	or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	
	Specify nature of costs 🕨	

