Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service	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).	2009
Department of Labor Employee Benefits Security Administration	Complete all entries in accordance with the instructions to the Form 5500.	2009
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	blan year beginning 09/01/2009 and ending 08/31/2	2010
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).
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	TING, INC. HEALTH BENEFITS PLAN	1b Three-digit plan number (PN) ▶ 501
	HNO, INC. HEALTH BENEFITOT EAN	1c Effective date of plan 09/01/2002
2a Plan sponsor's name and addres (Address should include room or s LIGHT SOURCES, INC.	s (employer, if for a single-employer plan) suite no.)	2b Employer Identification Number (EIN) 06-1074620
		2c Sponsor's telephone number 203-799-7877
37 ROBINSON BOULEVARD37 ROBINSON BOULEVARDORANGE, CT 06477ORANGE, CT 06477		2d Business code (see instructions) 335100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	02/03/2012	SUSAN ROCCHIO
mente	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
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.

Form 5500 (2009) v.092307.1

	Plan administrator's name and address (if same as plan sponsor, enter "Same") GHT SOURCES, INC.		Iministrator's EIN 1074620
	ROBINSON BOULEVARD ANGE, CT 06477	nu	Iministrator's telephone umber 3-799-7877
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	215
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		1
а	Active participants	6a	273
b	Retired or separated participants receiving benefits	6b	0
с	Other retired or separated participants entitled to future benefits	. 6c	0
d	Subtotal. Add lines 6a , 6b , and 6c	. 6d	273
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e	
f	Total. Add lines 6d and 6e	. 6f	273
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	

Form 5500 (2009)

Page 2

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A 4B 4D 4H

9a	a Plan funding arrangement (check all that apply)			9b	Plan be	enefit	t arra	ngement (check all that apply)
	(1)	X	Insurance		(1)	X	In	surance
	(2)		Code section 412(e)(3) insurance contracts		(2)		С	ode section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Т	rust
	(4)	X	General assets of the sponsor		(4)	X	G	eneral assets of the sponsor
10	Check a	all ap	plicable boxes in 10a and 10b to indicate which schedules are a	ttache	d, and,	wher	re inc	licated, enter the number attached. (See instructions)
а	Pensio	n <u>S</u> c	hedules	b	Genera	al <u>Sc</u>	ched	ules
а	Pensio (1)	n Sc	hedules R (Retirement Plan Information)	b	Genera (1)	al Sc	ched	ules H (Financial Information)
а		n Sc		b		al Sc	ched	
а	(1)	n Sc	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	b	(1)	al Sc	ched	H (Financial Information)
а	(1)	n Sci	R (Retirement Plan Information)MB (Multiemployer Defined Benefit Plan and Certain Money	b	(1) (2)	al Sc	ched	H (Financial Information)I (Financial Information – Small Plan)
а	(1)	n Sci	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	b	(1) (2) (3)	al So	ched	 H (Financial Information) I (Financial Information – Small Plan) A (Insurance Information)

SCHEDULE	A	Insuran	ce Informatio	n		0	
(Form 5500))						1B No. 1210-0110
Department of the Treas Internal Revenue Serv		This schedule is required Employee Retirement Ind					2009
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	500.			
Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2		ion	This For	rm is Open to Public Inspection
For calendar plan year 20	09 or fiscal plar	vear beginning 09/01/2009		and e	nding <mark>08</mark>	3/31/2010	-
A Name of plan LIGHT SOURCES, INC. 6	& LCD LIGHTIN	IG, INC. HEALTH BENEFITS PL	_AN		e-digit number (P	N) 🕨	501
C Plan sponsor's name a LIGHT SOURCES, INC.	as shown on line	⇒ 2a of Form 5500.		D Emplo 06-107	•	cation Number	(EIN)
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
SYMETRA LIFE INSURA	NCE COMPAN	Y					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a			Policy or contract year	
(5) EIN	code	identification number	policy or contrac		(f)	From	(g) To
91-0742147	68608	16010065000	2	71	08/01/2009		07/31/2010
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in item 3.	the agents	, brokers, and	other persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
3 Porcons receiving com	missions and fo	ees. (Complete as many entries	as pooded to report all	porconc)			
		nd address of the agent, broker,			ions or fees	were paid	
STIRLING BENEFITS, IN		20 AF	RMORY LANE ORD, CT 06460				
(b) Amount of sales ar	nd base	Fee	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	12347						5
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
							-
(b) Amount of sales ar	nd base	Fee	es and other commissio	ns paid			
commissions pa		(c) Amount	(d) Purpose (e) Organiz			(e) Organization code	

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

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

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid		

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

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

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	me and address of the agent, broke	me and address of the agent, broker, or other person to whom commissions or fees were paid			

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

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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er		5		
6		racts With Allocated Funds:				
a State the basis of premium rates						
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d 1	Fotal of balance and additions (add b and c(6))				
	e [Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		▶				
	((5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			7 f	

Schedule A (Form 5500) 2009

Page 4	ŀ
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Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts of	oup of employees of the a urposes if such contracts	are experien	ce-rated as a unit. Wh	ere contract		
8	Ben	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	еĪ	Temporary disability (accident and sickness)	f Long-term disabili	ity g	Supplemental unem	plovment	h Prescription drug	r
	i F	Stop loss (large deductible)	j HMO contract	., s∟ k[PPO contract	piojilioni		-
	. Ľ			r [I Indemnity contra	ict
	m	Other (specify)						
9	Evo	erience-rated contracts:						
3	•	Premiums: (1) Amount received		9a(1)			-	
	u	(2) Increase (decrease) in amount due but unpaid					-1	
		(3) Increase (decrease) in unearned premium res					1	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves					1	
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		-				
		(E) Taxes					_	
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	_	_				
		(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1	, ,			. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
4.0	e	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in c(2) .)		. 9e		
10	_	nexperience-rated contracts:				40		246022
	a ⊾	Total premiums or subscription charges paid to c				. 10a		246932
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
		reconsist of the contract of policy, other than repo	2 and 2 and 3 a	vo, report an			1	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40				

						[
SCHEDULE A Insurance Information				n		ОМ	B No. 1210-0110	
(Form 5500								
Department of the Treas Internal Revenue Servi		This schedule is required Employee Retirement In					2009	
Department of Labor Employee Benefits Security Ad		File as an a	attachment to Form 55	00.				
					m is Open to Public Inspection			
For calendar plan year 200	09 or fiscal plan	year beginning 09/01/2009		and er	nding 08	/31/2010		
A Name of plan LIGHT SOURCES, INC. & LCD LIGHTING, INC. HEALTH BENEFITS PLAN B Three-digit plan number (PN) 501					501			
C Plan sponsor's name as shown on line 2a of Form 5500. D Employer Identification Number (EIN) LIGHT SOURCES, INC. 06-1074620								
on a separat		ing Insurance Contract (Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca UNUM LIFE INSURANCE		FAMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To	
01-0278678	62235	122631	19 12/		12/01/20	009	11/30/2010	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in	
0	amount of comn	nissions paid		(b) To	otal amount	of fees paid		
		943						
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).				
	(a) Name ar	nd address of the agent, broker,		m commiss	ions or fees	s were paid		
BRIAN LUCIANI			ZEL TERRACE DBRIDGE, CT 06525					
(b) Amount of sales ar	nd base	Fee	es and other commissio	ns paid				
commissions paid		(c) Amount	(d) Purpose			(e) Organization code		
943						3		
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid				
commissions paid		(c) Amount	(c) Amount (d) Purpose		(e) Organization code			

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

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

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid	

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

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

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

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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d 1	Fotal of balance and additions (add b and c(6))				
	e [Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		▶				
	((5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			7 f	

Schedule A (Form 5500) 2009

m Other (specify) LONG TERM CARE

Pa	art III	Welfare Benefit Contract Information
		If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
8	Benefit	and contract type (check all applicable boxes)

8	Benefit and contract type (check all applicable boxes))	
	a Health (other than dental or vision)	b Dental	С
	e 🔲 Temporary disability (accident and sickness)	f Long-term disability	g
	i Stop loss (large deductible)	j HMO contract	k

c	Vision
g	Supplemental unemployment
k	PPO contract

Page 4

d	Life	insurance

h	Prescription	drug

I Indemnity contract

9

9	Expe	erience-rated contracts:				
	а	Premiums: (1) Amount received	9a(1)			
		(2) Increase (decrease) in amount due but unpaid	9a(2)			
		(3) Increase (decrease) in unearned premium reserve	9a(3)			
		(4) Earned ((1) + (2) - (3))			9a(4)	
	b	Benefit charges (1) Claims paid	9b(1)			
		(2) Increase (decrease) in claim reserves	9b(2)			
		(3) Incurred claims (add (1) and (2))			9b(3)	
		(4) Claims charged			9b(4)	
	С	Remainder of premium: (1) Retention charges (on an accrual basis)				
		(A) Commissions	9c(1)(A)			
		(B) Administrative service or other fees	9c(1)(B)			
		(C) Other specific acquisition costs	9c(1)(C)			
		(D) Other expenses	9c(1)(D)			
		(E) Taxes	9c(1)(E)			
		(F) Charges for risks or other contingencies	9c(1)(F)			
		(G) Other retention charges	9c(1)(G)			
		(H) Total retention			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)	
		(2) Claim reserves			9d(2)	
		(3) Other reserves			9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not include amount entered	d in c(2) .)		9e	
10	No	nexperience-rated contracts:				
	а	Total premiums or subscription charges paid to carrier			10a	6286
	b	If the carrier, service, or other organization incurred any specific costs in c				
		retention of the contract or policy, other than reported in Part I, item 2 above	ve, report am	iount	10b	L

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Y	es 🔉	No

SCHEDULE A Insurance Information (Form 5500)					OM	IB No. 1210-0110	
Department of the Treas Internal Revenue Serv			d to be filed under section 104 of the acome Security Act of 1974 (ERISA).			2009	
Department of Labor Employee Benefits Security Administration							
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 09/01/2009		and ei	nding <mark>08</mark>	8/31/2010	•
A Name of plan LIGHT SOURCES, INC.	& LCD LIGHTIN	G, INC. HEALTH BENEFITS PL	AN		e-digit number (P	N) 🕨	501
C Plan sponsor's name a LIGHT SOURCES, INC.	as shown on line	2a of Form 5500.		D Emplo 06-107	•	cation Number ((EIN)
		ing Insurance Contract C Individual contracts grouped as a					
(a) Name of insurance ca HARTFORD LIFE AND A							
		(d) Contract or	(e) Approximate number of			Policy or contract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
06-0838648	70815	ETB116004	01/0		01/01/20	010	12/31/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
(a) Total :	amount of comm			(b) To	otal amount	of fees paid	
		408					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
		nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
GROUP INSURANCE AS	SOCIATES		DBRIDGE, CT 06525				
(b) Amount of sales and base			s and other commission				
commissions paid 408		(c) Amount		(d) Purpos	e		(e) Organization code
400							5
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of color	nd hone	Fee	s and other commission	ns paid			
(b) Amount of sales and base commissions paid		(c) Amount	(d) Purpose			(e) Organization code	

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

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

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid	

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

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

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		

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

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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d 1	Fotal of balance and additions (add b and c(6))				
	e [Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		▶				
	((5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			7 f	

Schedule A (Form 5500) 2009

Page 4	4
--------	---

Pa	art III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts w	oup of employees of the s irposes if such contracts	are experienc	e-rated as a unit. Whe	ere contract	
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription drug
	iΓ	Stop loss (large deductible)	i HMO contract	k	PPO contract		I Indemnity contract
	m			L			
9	Expe	rience-rated contracts:					
	•	Premiums: (1) Amount received		9a(1)			1
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C)			_
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in c(2) .)		9e	
10	Nor	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	2720
	b	If the carrier, service, or other organization incurr					
		retention of the contract or policy, other than repo	orted in Part I, item 2 abov	ve, report ame	ount	10b	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	

SCHEDULE (Form 5500)		Insurance Information				OMB No. 1210-0110	
Department of the Treasu	ry		to be filed under section 10			0000	
Internal Revenue Service Department of Labor			come Security Act of 1974 (E ttachment to Form 5500.	RISA).		2009	
Employee Benefits Security Admi Pension Benefit Guaranty Corp		,	re required to provide the inf	ormation			
		pursuant to E	RISA section 103(a)(2).			rm is Open to Public Inspection	
For calendar plan year 2009 A Name of plan	9 or fiscal plan	year beginning 09/01/2009	_	J	08/31/2010		
	LCD LIGHTIN	IG, INC. HEALTH BENEFITS PL	AN	Three-digit plan number	(PN)	501	
Plan sponsor's name as LIGHT SOURCES, INC.	shown on line	2 2a of Form 5500.		Employer Iden 06-1074620	tification Number	(EIN)	
		ing Insurance Contract (Individual contracts grouped as a					
Coverage Information:		<u> </u>					
(a) Name of insurance carr	ier						
THE GUARDIAN LIFE INS	URANCE COI	MPANY OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate numbe		Policy or o	contract year	
(b) EIN	code	identification number	persons covered at end policy or contract yea		(f) From	(g) To	
13-5123390	64246	N4736	281	09/01	/2009	08/31/2010	
2 Insurance fee and comm descending order of the a		tion. Enter the total fees and tota	al commissions paid. List in	item 3 the age	nts, brokers, and	other persons in	
	nount of comn			(b) Total amou	unt of fees paid		
		4363					
3 Persons receiving comm		es. (Complete as many entries					
BRIAN LUCIANI	(a) Name ai		CEL TERRACE DBRIDGE, CT 06525		ees were paid		
		Foo	s and other commissions pa	id			
(b) Amount of sales and commissions paid		(c) Amount	•	urpose		(e) Organization code	
	4335	AD	MINISTRATION			3	
	(a) Name ar	nd address of the agent, broker,	or other person to whom cor	nmissions or fe	ees were paid		
GIANNINI & MOREY			RADLEY STREET HAVEN, CT 06510				
(b) Amount of sales and	base	Fee	s and other commissions pa	id			
commissions paid		(c) Amount	(d) P	urpose		(e) Organization code	
	16					3	

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

JOHN M LEE

30 BEACON STREET BRIDGEPORT, CT 06605

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
11			3	

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

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

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(c) No.	and address of the second busics		

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

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

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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d 1	Fotal of balance and additions (add b and c(6))				
	e [Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		▶				
	((5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			7 f	

		Schedule A (Form 5500) 2009		P	age 4			
Pa	rt II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts w	oup of employees of the s urposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contract		s,
8	Ben	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b 🛛 Dental	с	Vision		d X Life insurance	
	e	Temporary disability (accident and sickness)	f X Long-term disability	y g	Supplemental unem		h Prescription drug	
	: [· • _		pioyment		
	ין	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify) AD&D						
_								
9	•	erience-rated contracts:	г					
	а	Premiums: (1) Amount received	-	9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)			4	
		(3) Increase (decrease) in unearned premium res	-					
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid		. ,			4	
		(2) Increase (decrease) in claim reserves	-			at (a)		
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
	_	(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (o	́г г	0.(4)(4)				
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)			4	
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			4	
		(E) Taxes		9c(1)(E) 9c(1)(F)			4	
		(F) Charges for risks or other contingencies		9c(1)(G)			4	
		(G) Other retention charges	-			0c(1)/凵)		_
		(H) Total retention	_	_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1						
		(2) Claim reserves				. 9d(2)		
	-	(3) Other reserves				. 9d(3)		
40	e	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	ın c(2) .)		. 9e		
10		nexperience-rated contracts:				10	40	593
	-	Total premiums or subscription charges paid to c	arriar			10-2	4.3	243

Total premiums or subscription charges paid to carrier а **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... 10b

Specify nature of costs 🕨

Ра	rt IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12	If the answer to line 11 is "Vec." analytic the information not provided			

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal plan year beginning A Name of plan LIGHT SOURCES, INC. & LCD LIGHTING, INC. HEAL C Plan sponsor's name as shown on line 2a of Form 5 LIGHT SOURCES, INC. Part I Service Provider Information (see You must complete this Part, in accordance with the or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per 1 Information on Persons Receiving Only a Check "Yes" or "No" to indicate whether you are exclinidirect compensation for which the plan received the plan received only eligible indirect compensation. Complete the figure and EIN or at the compensation. Complete the figure and EIN or at the compensation. Complete the plan are and EIN or at the plan and EIN or at the plan and EIN or at the plan are and EIN or at the plan and	lule is required to be filed under sec				
Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal plan year beginning A Name of plan LIGHT SOURCES, INC. & LCD LIGHTING, INC. HEAL C Plan sponsor's name as shown on line 2a of Form 5 LIGHT SOURCES, INC. Part I Service Provider Information (see You must complete this Part, in accordance with the or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per 1 Information on Persons Receiving Only a Check "Yes" or "No" to indicate whether you are exclinidirect compensation for which the plan received the persenvent of the plan received only eligible indirect compensation. Complete the received only eligible indirect compensation. Complete the figure and EIN or a GROUP INSURANCE ASSOCIATES 06-1423803		tion 104 of the Employee	2009		
Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal plan year beginnin A Name of plan LIGHT SOURCES, INC. & LCD LIGHTING, INC. HEAL C Plan sponsor's name as shown on line 2a of Form 5 LIGHT SOURCES, INC. Part I Service Provider Information (se You must complete this Part, in accordance with the or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per 1 Information on Persons Receiving Only a Check "Yes" or "No" to indicate whether you are excl indirect compensation for which the plan received the b If you answered line 1a "Yes," enter the name and E received only eligible indirect compensation. Complete (b) Enter name and EIN or a GROUP INSURANCE ASSOCIATES 06-1423803	Retirement Income Security Act of				
For calendar plan year 2009 or fiscal plan year beginnin A Name of plan LIGHT SOURCES, INC. & LCD LIGHTING, INC. HEAL C Plan sponsor's name as shown on line 2a of Form 5 LIGHT SOURCES, INC. Part I Service Provider Information (se You must complete this Part, in accordance with the or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per I Information on Persons Receiving Only a Check "Yes" or "No" to indicate whether you are excl indirect compensation for which the plan received the b If you answered line 1a "Yes," enter the name and EIN or a GROUP INSURANCE ASSOCIATES	File as an attachment to F	orm 5500.	This F	orm is Open to Public Inspection.	
C Plan sponsor's name as shown on line 2a of Form 5 LIGHT SOURCES, INC. Part I Service Provider Information (se You must complete this Part, in accordance with the or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per I Information on Persons Receiving Only C C C C C C C C C C C C C C C C C C C	ng 09/01/2009	and ending 08/31	/2010	•	
LIGHT SOURCES, INC. Part I Service Provider Information (service or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per 1 Information on Persons Receiving Only 2 Check "Yes" or "No" to indicate whether you are excludered compensation for which the plan received the preceived only eligible indirect compensation. Complete the plan received only eligible indirect	TH BENEFITS PLAN	B Three-digit plan number (PN)	•	501	
You must complete this Part, in accordance with the or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per 1 Information on Persons Receiving Only a Check "Yes" or "No" to indicate whether you are excl indirect compensation for which the plan received the policy of the plan indirect compensation. Complete (b) Enter name and EIN or a GROUP INSURANCE ASSOCIATES	500	D Employer Identification Number (EIN) 06-1074620			
or more in total compensation (i.e., money or anythir plan during the plan year. If a person received only answer line 1 but are not required to include that per 1 Information on Persons Receiving Only a Check "Yes" or "No" to indicate whether you are excl indirect compensation for which the plan received the b If you answered line 1a "Yes," enter the name and E received only eligible indirect compensation. Complet (b) Enter name and EIN or a GROUP INSURANCE ASSOCIATES 06-1423803	e instructions)				
(b) Enter name and EIN or a GROUP INSURANCE ASSOCIATES 06-1423803	y Eligible Indirect Compen uding a person from the remainder e required disclosures (see instruct EIN or address of each person prov	sation of this Part because they recei ions for definitions and conditio iding the required disclosures fo	ns)	XYes No	
GROUP INSURANCE ASSOCIATES 06-1423803	address of person who provided yo	,	t compensa	tion	
	8 HAZEL TERRACE WOODBRIDGE, CT 0652				
(b) Enter name and EIN or a					
	address of person who provided yo	u disclosure on eligible indirect	compensati	on	
(b) Enter name and EIN or a	address of person who provided you	u disclosures on eligible indirec	t compensat	ion	
(b) Enter name and EIN or a	ddroce of porson who provided us	u disclosuros on oligible indires	t compensat	tion	

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)						
STIRLING BENEFITS, INC. 20 ARMORY LANE						
			MILFORI	D, CO 06460		
06-0892635	5					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	12347	Yes 🗌 No 🔀	Yes 🗌 No 🛛	0	Yes 🗌 No 🗙
		(a) Enter name and EIN or	address (see instructions)		
GROUP IN	SURANCE ASSOCIA	TES		TERRACE RIDGE, CT 06525		
			WOODDI	NDOL, 01 00323		
06-1423803	3					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		21180	Yes 🗌 No 🕅	Yes No		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
AWAC, LLC - IPROCERT 3626 WALTON WAY EXTENSION AUGUSTA, GA 30909						
26-0381227						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12		5930	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗌

(a) Enter name and EIN or address (see instructions)						
MULTIPLAN/PHCS 115 FIFTH AVENUE						
			NEW YO	RK, NY 10003		
13-3068979	Э					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12		17489	Yes 🗌 No 🔀	Yes No		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
AWAC, LLC	C -SAVINGS FEE			LTON WAY EXTENSION		
			AUGUST	FA, GA 30909		
26-0381227	7					
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12		10452	Yes 🗌 No 🔀	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
AWAC, LLC - CM 3626 WALTON WAY EXTENSION AUGUSTA, GA 30909						
26-038122	7					
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12		9043	Yes 🗌 No 📉	Yes 🗌 No 🗌		Yes 🗌 No 🗌

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility
	for or the amount of the	he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect of	compensation, including any
	formula used to determine	the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect of	compensation, including any
	formula used to determine	the service provider's eligibility he indirect compensation.

Page 6-	1
Page 6-	1

Part II Service Providers Who Fail or Refuse to	Provide Inform	nation
4 Provide, to the extent possible, the following information for ea this Schedule.	ach service provide	r who failed or refused to provide the information necessary to complete
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide

Page	7-	1
i ugo	•	

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			
a Name:	b EIN:		
C Position:			
d Address:	e Telephone:		
Explanation:			
	L =		
a Name:	b EIN:		
C Position: d Address:	e Telephone:		
a Address.	e relepitone.		
Explanation:			
a Name:	b EIN:		
C Position:			
d Address:	e Telephone:		
Fundametica			
Explanation:			
a Name:	b EIN;		
C Position:			
d Address:	e Telephone:		
Explanation:			

а	Name:	b EIN;
С	Position:	
d	Address:	e Telephone:

Explanation: