Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

HERE

Signature of DFE

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2010

	, , , , , , , , , , , , , , , , , , , ,				Inis Form is Open to Pu Inspection	JDIIC
Part I	Annual Report Iden	tification Information		<u>.</u>		
For cale	ndar plan year 2010 or fiscal p	plan year beginning 06/01/2010		and ending 05/31/2	011	
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or		
		a single-employer plan;	a DFE (s	pecify)		
		_				
B This	return/report is:	the first return/report;	the final r	eturn/report;		
		X an amended return/report;	a short p	lan year return/report (less th	an 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here				
D Chec	k box if filing under:	Form 5558;	automatio	c extension;	the DFVC program;	
	J	special extension (enter des				
Part	II Basic Plan Inform	nation—enter all requested informa	· ,			
	ne of plan				1b Three-digit plan	501
TOTAL I	BANK FLEXIBLE BENEFITS	PLAN			number (PN) ▶	
					1c Effective date of pla 05/05/1994	an
2a Plar	sponsor's name and address	s (employer, if for a single-employer p	olan)		2b Employer Identifica	ation
	ress should include room or s		,		Number (EIN)	
TOTAL	BANK				59-1498440	
					2c Sponsor's telephone number	
					305-476-6321	
	DRAL WAY, 4TH FLOOR FL 33145	2720 COR MIAMI, FL	RAL WAY, 4TH FLOOR . 33145		2d Business code (see	
		,		instructions)		
					522110	
	<u> </u>	complete filing of this return/repor				
		penalties set forth in the instructions, I as the electronic version of this return				
Statemen	no ana attaorimento, ao wen t	as the electronic version of this return	Topon, and to the b	l l l l l l l l l l l l l l l l l l l	ioi, it io true, correct, and corr	ipicto.
SIGN	Filed with authorized/valid ele	ectronic signature.	03/24/2012	LOURDES REY WILSON		
HERE		<u> </u>	Data	Enter name of individual signing as plan administrator		
	Signature of plan adminis	trator	Date	Enter name of individual sign	gning as pian administrator	
SIGN						
HERE	a		5.			
	Signature of employer/pla	in sponsor	Date	Enter name of individual sign	gning as employer or plan sp	onsor
SIGN						

Date

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

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

Form 5500 (2010) Page **2**

	Plan administrator's name and address (if same as plan sponsor, enter "Sar TAL BANK	ne")	3b Administrator's EIN 59-1498440		
	0 CORAL WAY, 4TH FLOOR MI, FL 33145		nu	ministrator's telephone mber 5-476-6321	
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for this plan, enter the name, EIN	and	4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year		5	750	
6	Number of participants as of the end of the plan year (welfare plans complet	te only lines 6a, 6b, 6c, and 6d).			
а	Active participants		. 6a	827	
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	827	
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive 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 complete this item)	. 6g			
h	Number of participants that terminated employment during the plan year with 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		
	If the plan provides pension benefits, enter the applicable pension feature confidence of the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4F 4H 4L				
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 (1) X Insurance (2) Code section 412(e)(3) Trust (4) General assets of the specific production of the	insurand		
10 a	Check all applicable boxes in 10a and 10b to indicate which schedules are 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	b General Schedules (1) H (Financial Inform (2) I (Financial Inform (3) X 6 A (Insurance Inform (4) X C (Service Provide (5) D (DFE/Participation	nation) nation – mation) er Inform ng Plan	Small Plan) ation) Information)	
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction S	Schedules)	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2010

This Form is Open to Public Inspection

		F 31.0 22.0 11.0			inspection
For calendar plan year 20	10 or fiscal plan	year beginning 06/01/2010	an	d ending 05/31/2011	
A Name of plan TOTAL BANK FLEXIBLE	BENEFITS PLA	AN		hree-digit blan number (PN)	501
C Plan sponsor's name a TOTAL BANK	s shown on line	2a of Form 5500.		nployer Identification Number 1498440	r (EIN)
on a separat		ing Insurance Contract C Individual contracts grouped as a			
1 Coverage Information:					
(a) Name of insurance ca	rrier				
			(e) Approximate number of	f Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year		(g) To
23-2229683	95088	US291642	827	06/01/2010	05/31/2011
2 Insurance fee and communication descending order of the		tion. Enter the total fees and tota	Il commissions paid. List in ite	m 3 the agents, brokers, and	other persons in
(a) Total a	amount of comn	nissions paid	(b) Total amount of fees paid	
		68478			0
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons	s).	
		nd address of the agent, broker,		•	
KAHN CARLIN & COMPA	ANY INC		SOUTH DIXIE HWY	·	
		MIAMI	, FL 33133		
(b) Amount of sales ar	nd hans	Fee	s and other commissions paid		
commissions pai		(c) Amount	(d) Pur	(e) Organization code	
·	44478		, , ,		3
	(a) Name ar	nd address of the agent, broker,	or other person to whom comn	nissions or fees were paid	
SEITLIN BENEFITS COR		9800 N SUITE	NW 41 STREET		
			and other commissions said		
(b) Amount of sales and base commissions paid		(c) Amount	s and other commissions paid (d) Purp	oose	(e) Organization code
24000 (C) Amount			, , , ,		3
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 55	500. Sc	hedule A (Form 5500) 2010

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

Pa	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for	nurnoses of
		this report.	iddai cominacts with Co	on ourner may be treated as a drill for	parposos or
4 (Curre	ent value of plan's interest under this contract in the general account at year	end		
5 (Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Conti	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		60	
		Specify nature of costs			
	е	Type of contract: (1) individual policies	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check born	▶ □	
7 ′		racts With Unallocated Funds (Do not include portions of these contracts ma		r 📙	
			intained in separate a ite participation guarai		
	а	· / 🕒 · · · · · · · · · · · · · · · · · ·		nee	
		(3) guaranteed investment (4) other			
		Balance at the end of the previous year		7b	
		Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions			C
		Total of balance and additions (add b and c(6))		7d	C
		Deductions:	70(4)		
		(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			
		(4) Other (specify below)	. 7e(4)		
		•			
		(5) Total deductions			С
	f	Balance at the end of the current year (subtract e(5) from d)		7f	0

Page	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 v	oup of employees of the surposes if such contracts	are experi	ieńc	e-rated as a unit. W	here contrac	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	(C	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	gΠ	Supplemental unen	nployment	h Prescription drug
	iΓ	Stop loss (large deductible)	j HMO contract		k∏	PPO contract		I Indemnity contract
	m	Other (specify)	,	•	Ш			I I machinity deminder
	m	Other (specily)						
9	=xne	erience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res		9a(3)				
		(4) Earned ((1) + (2) - (3))	· ·				9a(4)	0
		Benefit charges (1) Claims paid	i	9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))					9b(3)	0
		(4) Claims charged					9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A	(۱			
		(B) Administrative service or other fees		9c(1)(E	_			
		(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	•)
		(H) Total retention	_		_		9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	С	redited.)	_ ` '	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits a	fter	retirement		
		(2) Claim reserves						
		(3) Other reserves					•	
	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in c(2) .)			9e	
10	_	nexperience-rated contracts:					40	2815394
	a	Total premiums or subscription charges paid to c					<u>10a</u>	2010094
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo					10b	
	Sn	ecify nature of costs	nted in Fait I, item 2 abov	vo, roport	unic	, and		
	Op	cony nature or cools						
De	r4 IV	/ Provision of Information						
Pa							1 ,,	▼
<u>11</u>	Dic	I the insurance company fail to provide any inform	ation necessary to compl	ete Sched	alub	A?	Yes	× No

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

			ERISA section 103(a)(2).	11113 1 011	m is Open to Public Inspection		
For calendar plan year 20	10 or fiscal pla	n year beginning 06/01/2010	and er				
A Name of plan TOTAL BANK FLEXIBLE	BENEFITS PL	_AN		e-digit number (PN)	501		
C Plan sponsor's name a TOTAL BANK	s shown on lin	e 2a of Form 5500.	D Emplo 59-148	oyer Identification Number (98440	EIN)		
on a separat			Coverage, Fees, and Comes a unit in Parts II and III can be reported				
1 Coverage Information:							
(a) Name of insurance ca AETNA, INC.	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
06-6033492	60054	883864	630	630 06/01/2010			
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. List in item 3	the agents, brokers, and c	other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
6599							
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all persons).				
			r, or other person to whom commiss	ions or fees were paid			
KAHN, CARLIN & COMP.	ANY INC		O SOUTH DIXIE HWY MI, FL 33133				
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid				
commissions pa		(c) Amount	(d) Purpose	(e) Organization code			
	6599				3		
	(a) Name a	and address of the agent, broke	r, or other person to whom commiss	ions or fees were paid			
	(a) Hamo	and address of the agent, broke	, or other person to whom commission	none or rose were para			
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid				
commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code		

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

Pa	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for	nurnoses of
		this report.	iddai cominacts with Co	on ourner may be treated as a drill for	parposos or
4 (Curre	ent value of plan's interest under this contract in the general account at year	end		
5 (Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Conti	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		60	
		Specify nature of costs			
	е	Type of contract: (1) individual policies	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check born	▶ □	
7 /		racts With Unallocated Funds (Do not include portions of these contracts ma		r 📙	
			intained in separate a ite participation guarai		
	а	· / 🕒 · · · · · · · · · · · · · · · · · ·		nee	
		(3) guaranteed investment (4) other			
		Balance at the end of the previous year		7b	
		Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions			C
		Total of balance and additions (add b and c(6))		7d	C
		Deductions:	70(4)		
		(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			
		(4) Other (specify below)	. 7e(4)		
		•			
		(5) Total deductions			С
	f	Balance at the end of the current year (subtract e(5) from d)		7f	0

Page	4

P	art III	weitare Benefit Contract Informa					
		If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	ourposes if such contracts	are experience	ce-rated as a unit. Wh	ere contrac	
8	Benefi	it and contract type (check all applicable boxes))				
	а □	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
		Temporary disability (accident and sickness)	f ☐ Long-term disabili	_	<u>.</u> 1	olovment	h Prescription drug
	iΗ	Stop loss (large deductible)	j HMO contract	.,y g_ k□	PPO contract	pioymoni	I Indemnity contract
	m∏	Other (specify)) [] Time contract		11 0 donardor		I I indemnity contract
	'''' □	Other (specify)					
9	Evneri	ence-rated contracts:					
Ū	•	remiums: (1) Amount received		9a(1)			7
		2) Increase (decrease) in amount due but unpai					7
	,	B) Increase (decrease) in unearned premium res					7
		4) Earned ((1) + (2) - (3))				9a(4)	0
	_ `	Benefit charges (1) Claims paid				,	
	(2	2) Increase (decrease) in claim reserves		21 (2)			7
	•	3) Incurred claims (add (1) and (2))				9b(3)	0
	(4	4) Claims charged				9b(4)	
	C F	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					
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	<u>.</u>	<u></u>		9c(1)(H)) 0
	(2	Dividends or retroactive rate refunds. (These	e amounts were 📗 paid ir	n cash, or	credited.)	9c(2)	
	d 8	Status of policyholder reserves at end of year: (1	1) Amount held to provide	benefits after	retirement	9d(1)	
	(2	2) Claim reserves				9d(2)	
	(;	3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do n	not include amount entere	d in c(2) .)		. 9e	
1		experience-rated contracts:					404470
	_	Total premiums or subscription charges paid to o				10a	191479
		f the carrier, service, or other organization incur etention of the contract or policy, other than rep				10b	
		1 3,	oned in Fait I, item 2 abo	ive, report ann	ount	100	
	Spe	cify nature of costs					
P	art IV	Provision of Information					

X No

Yes

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

For calendar plan year 2010 or fiscal plan year paginning 0601/2010 and ending 0501/2011 A Namo of plan TOTAL BANK FLEXIBLE BENEFITS PLAN B Three-digit plan number (PN)	,	. ,		ERISA section 103(a)(2).	e iniormatio	on	This Fo	m is Open to Public Inspection
A Name of plan TOTAL BANK FLEXIBLE BENEFITS PLAN B Three-digit plan number (PN)	For calendar plan year 20	010 or fiscal pla	n year beginning 06/01/2010)	and en	ding 05/31	1/2011	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN	A Name of plan	-				J	•	501
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN								
n a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN (c) NAIC code (d) Contract or identification number of persons covered at end of policy or contract year persons covered at end of policy or contract year (f) From (g) To 35-0472300 70254 000010064950 400 06/01/2010 05/31/2011 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 9 13475 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		as shown on lin	e 2a of Form 5500.				ion Number	(EIN)
1 Coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year poli								
(a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons overed at end of policy or contract year persons in descending order of the amount paid. 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code Fees and other commissions paid (e) Amount of sales and base person to whom commissions or fees were paid			individual contracts grouped a	s a unit in Parts il and ili ca	ап ве геро	nteu on a sing	jie Scriedule	: A.
(b) EIN (c) NAIC (d) Contract or identification number persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year (f) From (g) To 35-0472300 70254 000010064950 400 06/01/2010 05/31/2011 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 3								
(b) EIN (c) NAIC code identification number persons covered at end of persons covered at end of policy or contract year persons covered at end of policy or contract year (g) To 35-0472300 70254 000010064950 400 06/01/2010 05/31/2011 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 13475 00 Total amount of fees paid 13475 00 Total amount of fees paid 13475 00 Total amount of fees were paid 13475 Name and address of the agent, broker, or other person to whom commissions or fees were paid 13475 Name and address of the agent, broker, or other person to whom commissions or fees were paid 13475 00 Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 31 Name and address of the agent, broker, or other person to whom commissions or fees were paid 13475 13475 13475 13475 13475 Purpose (e) Organization code 13475 13475 Purpose Fees and other commissions paid (c) Amount for sales and base Fees and other commissions paid (e) Organization code 13475 Purpose Fees and other commissions paid (e) Organization code 13475 Purpose Fees and other commissions paid (e) Organization code 13475 Purpose Fees and other commissions paid (e) Organization code 13475 Purpose Fees and other commissions paid (e) Organization code 13475 Purpose Fees and other commissions paid (e) Organization code 13475 Purpose Fees and other commissions paid (e) Organization code 13475 Purpose Fees and other commissions paid (e) Organization code 13475 Purpose Policy or contract year of the person to whom commissions paid (e) Organization code 13475 Purpose Policy or contract year of the person to whom commissions paid (e) Organization code 13475 Purpose Policy or contract year of the person to whom commissions paid (e) Organization code 13475 Purpose Policy or contract year of the person to whom commissions paid (e) O	` '							
(b) EIN (c) NAIC (d) defidentification number persons covered at end of policy or contract year (f) From (g) To 35-0472300 70254 00001064950 400 06/01/2010 05/31/2011 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 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 Fees and other commissions paid (e) Organization code 13475 3 (b) Amount of sales and base Fees and other commissions or fees were paid	THE LINCOLN NATIONA	AL LIFE INSUR	ANCE COMPANY					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (c) Amount (d) Name and address of the agent, broker, or other person to whom commissions or fees were paid (e) Organization 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 (c) Amount (d) Purpose (e) Organization code 13475 (b) Amount of sales and base Fees and other commissions or fees were paid	4 > = 0 :	(c) NAIC	(d) Contract or				Policy or c	ontract year
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid	(b) EIN			·		(f) F	rom	(g) To
(a) Total amount of commissions paid (b) Total amount of fees paid 13475 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 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 report all persons).	35-0472300	70254	000010064950	400)	06/01/2010)	05/31/2011
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 3 (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid			ation. Enter the total fees and to	otal commissions paid. List	t in item 3	the agents, bi	rokers, and	other persons in
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base	(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid						
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KAHN CARLIN & COMPANY INC 3350 SOUTH DIXIE HWY MIAMI, FL 33133 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			13475					0
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization 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 or fees were paid	3 Persons receiving com	nmissions and f	ees. (Complete as many entrie	s as needed to report all pe	ersons).			
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 (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 (b) Amount of sales and base		(a) Name a			commission	ons or fees we	ere paid	
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 13475 (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	KAHN CARLIN & COMP	ANY INC						
(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 (c) Amount (d) Purpose (e) Organization code 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 Fees and other commissions paid (c) Amount (d) Purpose (e) Organization code 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 Fees and other commissions paid	(b) Amount of sales a	nd base	Fe	ees and other commissions	paid			
(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 pa		(c) Amount	(0	d) Purpose	!		
(b) Amount of sales and base Fees and other commissions paid		13475						3
(b) Amount of sales and base Fees and other commissions paid								
(b) Amount of sales and base Fees and other commissions paid		(a) Nome of	and address of the agent brake	r or other person to whom	commissi	one or food	oro poid	
(b) Amount of sales and base		(a) Name a	and address of the agent, broke	r, or other person to whom	COMMISSIO	ons or rees we	ere paid	
(b) Amount of sales and base								
(b) Amount of sales and base								_
commissions paid (c) Amount (d) Purpose (e) Organization code	(b) Amount of sales a	nd base _	Fe	ees and other commissions	paid			_
	commissions pa	aid	(c) Amount	(0	d) Purpose	!		(e) Organization code

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

Pa	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for	nurnoses of
		this report.	iddai cominacts with Co	on ourner may be treated as a drill for	parposos or
4 (Curre	ent value of plan's interest under this contract in the general account at year	end		
5 (Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Conti	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		60	
		Specify nature of costs			
	е	Type of contract: (1) individual policies	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check born	▶ □	
7 /		racts With Unallocated Funds (Do not include portions of these contracts ma		r 📙	
			intained in separate a ite participation guarai		
	а	· / 🕒 · · · · · · · · · · · · · · · · · ·		nee	
		(3) guaranteed investment (4) other			
		Balance at the end of the previous year		7b	
		Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions			C
		Total of balance and additions (add b and c(6))		7d	C
		Deductions:	70(4)		
		(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			
		(4) Other (specify below)	. 7e(4)		
		•			
		(5) Total deductions			С
	f	Balance at the end of the current year (subtract e(5) from d)		7f	0

Page	4

Part III	weitare Benefit Contract Informa						
	If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experience	ce-rated as a unit. V	Vhere contrac		
8 Benefi	it and contract type (check all applicable boxes))					
	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
e	Temporary disability (accident and sickness)	f Long-term disabil	itv a	Supplemental une	mplovment	h Prescription drug	
	Stop loss (large deductible)	j HMO contract	· - <u>-</u>	PPO contract	1 -7 -	I Indemnity contract	
m⊠	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT	~ <u>_</u>	11 O contract		I ☐ Indefinity contract	
9 Experie	ence-rated contracts:						
a Pre	emiums: (1) Amount received		. 9a(1)				
(2	2) Increase (decrease) in amount due but unpai	d	. 9a(2)				
(3	B) Increase (decrease) in unearned premium re	serve	. 9a(3)				
(4	4) Earned ((1) + (2) - (3))				9a(4)		0
b B	Benefit charges (1) Claims paid		. 9b(1)				
(2	2) Increase (decrease) in claim reserves		. 9b(2)				
(3	3) Incurred claims (add (1) and (2))				9b(3)		0
	l) Claims charged						
C R	Remainder of premium: (1) Retention charges (on an accrual basis)					
	(A) Commissions		9c(1)(A)				
	(B) Administrative service or other fees		2 (1)(7)				
	(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)			7	
	(H) Total retention				9c(1)(H)		0
(2	 Dividends or retroactive rate refunds. (These 	_					
	Status of policyholder reserves at end of year: (-	
	2) Claim reserves	•					
· ·	3) Other reserves					-	
`	Dividends or retroactive rate refunds due. (Do r						
	experience-rated contracts:	iot include amount entere	a iii c(z) .)		36		
	otal premiums or subscription charges paid to	carrier			10a	2	41932
	the carrier, service, or other organization incur				100		
	etention of the contract or policy, other than rep	orted in Part I, item 2 abo	ve, report am	ount	10b		
Spec	cify nature of costs 🕨						
	_						
Part IV	Provision of Information						
11 Did th	he insurance company fail to provide any inforr	nation necessary to comp	lete Schedule	A?	Yes	X No	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Co	n				on		m is Open to Public Inspection
For calendar plan year 20	10 or fiscal pl	an year beginning 06/01/201	0	and en	ding 05	/31/2011	
A Name of plan TOTAL BANK FLEXIBLE	BENEFITS F	PLAN		B Three plan r	-digit number (PI	N) •	501
C Plan sponsor's name a TOTAL BANK	as shown on li	ne 2a of Form 5500.		D Employ 59-1498		cation Number (EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		RANCE COMPANY	(a) Assuration of			Dollary or on	antro et un or
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a	it end of	(f)	Policy or co	(g) To
05.0470000			policy or contrac				
35-0472300	70254	000010119960	3	75	11/01/20)10	12/31/2010
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and c	ther persons in
(a) Total a	amount of cor	mmissions paid		(b) Tot	tal amount	of fees paid	
		4516					0
3 Persons receiving com		fees. (Complete as many entrie					
KALIN CARLIN 9 COMP		and address of the agent, broke	er, or other person to who	m commission	ons or fees	were paid	
KAHN CARLIN & COMP/	ANY INC		AMI, FL 33133				
		F	ees and other commission	ns naid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	4516						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commission	ons or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

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

Pa	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for	nurnoses of
		this report.	iddai cominacts with Co	on ourner may be treated as a drill for	parposos or
4 (Curre	ent value of plan's interest under this contract in the general account at year	end		
5 (Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Conti	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		60	
		Specify nature of costs			
	е	Type of contract: (1) individual policies	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check born	▶ □	
7 /		racts With Unallocated Funds (Do not include portions of these contracts ma		r 📙	
			intained in separate a ite participation guarai		
	а	· / 🕒 · · · · · · · · · · · · · · · · · ·		nee	
		(3) guaranteed investment (4) other			
		Balance at the end of the previous year		7b	
		Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions			C
		Total of balance and additions (add b and c(6))		7d	C
		Deductions:	70(4)		
		(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			
		(4) Other (specify below)	. 7e(4)		
		•			
		(5) Total deductions			С
	f	Balance at the end of the current year (subtract e(5) from d)		7f	0

Page	4

Pa	art II	If more than one contract covers the same gro information may be combined for reporting pu	oup of irpose:	s if such co	ntracts a	re experie	enc	e-rated as a unit. Whe	ere contra		
_		the entire group of such individual contracts w	vitn ea	cn carrier ir	iay be tr	eated as a	a ur	nit for purposes of this	героп.		
8	Ben	efit and contract type (check all applicable boxes)	_							_	
	а	Health (other than dental or vision)	b	Dental		C	;	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f	Long-term	disability	, g		Supplemental unemp	loyment	h Prescription drug	
	i	Stop loss (large deductible)	j 🗌	HMO contr	act	k		PPO contract		I Indemnity contract	
	m	Other (specify)								_	
9	Ехре	erience-rated contracts:									
	а	Premiums: (1) Amount received				9a(1)					
		(2) Increase (decrease) in amount due but unpaid	l			9a(2)					
		(3) Increase (decrease) in unearned premium rese			· -	9a(3)					
		(4) Earned ((1) + (2) - (3))							9a(4)		0
	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)		0
		(4) Claims charged							9b(4)		
	С	Remainder of premium: (1) Retention charges (or			· –						
		(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			<u> </u>	9c(1)(D	_				
		(E) Taxes			<u> </u>	9c(1)(E					
		(F) Charges for risks or other contingencies			-	9c(1)(F)					
		(G) Other retention charges				9c(1)(G)				
		(H) Total retention		<u></u>					9c(1)(H)	0
		$\begin{tabular}{ll} \end{tabular} \begin{tabular}{ll} \end{tabular} \beg$	amou	nts were	paid in	cash, or	c	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)) Amoι	unt held to p	orovide b	enefits af	ter	retirement	9d(1)		
		(2) Claim reserves							9d(2)		
		(3) Other reserves							9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot inclu	de amount	entered	in c(2) .) .			9e		
10	No	nexperience-rated contracts:									
	а	Total premiums or subscription charges paid to ca	arrier .						10a	6	57860
		If the carrier, service, or other organization incurred retention of the contract or policy, other than repo		•				•	10b		
	Sμ	ecify nature of costs									
	rt IV	Provision of Information If the insurance company fail to provide any information	ation r	necessary to	a comple	ata School	ulo	Δ2 Π	Yes	⊠ No	
	טוע	i ino modrance company fan to provide any illionni	auviil	iooosaiy ll	o oompit	, co ou lea	uiC	/ \ :		11.55	

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corp	n.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				m is Open to Public Inspection		
For calendar plan year 2010	or fiscal pla	an year beginning 06/01/201	0	and en	ding 05	/31/2011	
A Name of plan TOTAL BANK FLEXIBLE E	BENEFITS P	LAN		B Three plan	e-digit number (Pl	N) •	501
C Plan sponsor's name as TOTAL BANK	shown on lir	ne 2a of Form 5500.		D Employ 59-1498		cation Number (EIN)
		ning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance carr THE LINCOLN NATIONAL		RANCE COMPANY				Deli	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate no persons covered a		(f)	From	ontract year
		identification number	policy or contract	t year	(1)	FIOIII	(g) To
35-0472300	70254	000010119959	3	75	11/01/20)10	12/31/2010
2 Insurance fee and comm descending order of the a		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
(a) Total ar	mount of com	nmissions paid		(b) Tot	tal amount	of fees paid	
		4821					0
3 Persons receiving comm		fees. (Complete as many entrie					
KAHN CARLIN & COMPAN			er, or other person to who 50 SOUTH DIXIE HWY AMI, FL 33133	m commissi	ons or fees	were paid	
(b) Amount of sales and	d base	F	ees and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose	1		(e) Organization code
	4821						3
	(a) Name	and address of the agent, broke	er or other person to who	m commissi	one or fees	were paid	
	(a) Name	and address of the agent, broke	er, or other person to who	III COITIITII55II	ons or rees	were paid	
(b) Amount of sales and		F	ees and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for	nurnoses of
		this report.	iddai comiacis will ea	on ourner may be treated as a drill for	parposos or
4 (Curre	ent value of plan's interest under this contract in the general account at year	end		
5 (Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Conti	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		60	
		Specify nature of costs			
	е	Type of contract: (1) individual policies	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check born	▶ □	
7 /		racts With Unallocated Funds (Do not include portions of these contracts ma		r 📙	
			intained in separate a ite participation guarai		
	а	· / 🕒 · · · · · · · · · · · · · · · · · ·		nee	
		(3) guaranteed investment (4) other			
		Balance at the end of the previous year		7b	
		Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions			C
		Total of balance and additions (add b and c(6))		7d	C
		Deductions:	70(4)		
		(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			
		(4) Other (specify below)	. 7e(4)		
		•			
		(5) Total deductions			С
	f	Balance at the end of the current year (subtract e(5) from d)		7f	0

Page	4

Pa	rt II					()			
		If more than one contract covers the same grainformation may be combined for reporting puthe entire group of such individual contracts of the entire group of such individual contracts of the same grainformation and the same gr	urposes	s if such contracts a	re experienc	ce-rated as a unit. Wh	nere contrac		
8	Ben	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	b	Dental	С	Vision		d Life insurance	e
	е	Temporary disability (accident and sickness)	f	Long-term disability	, g	Supplemental unem	ployment	h Prescription	drug
	ιŤ	Stop loss (large deductible)		HMO contract	k	PPO contract		I Indemnity co	ontract
	m	Other (specify)	, ,		<u>L</u>	_		- <u> </u>	
	∟	_ Caron (openity) /							
9	Ехре	erience-rated contracts:							
	a i	Premiums: (1) Amount received			9a(1)				
		(2) Increase (decrease) in amount due but unpaid	d		9a(2)				
		(3) Increase (decrease) in unearned premium res			9a(3)				
		(4) Earned ((1) + (2) - (3))		_			. 9a(4)		0
	_	Benefit charges (1) Claims paid			9b(1)				
		(2) Increase (decrease) in claim reserves		F					
		(3) Incurred claims (add (1) and (2))		<u>_</u>			. 9b(3)		0
		(4) Claims charged					. 9b(4)		
		Remainder of premium: (1) Retention charges (o							
		(A) Commissions		<u>´</u>	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)	0
		(2) Dividends or retroactive rate refunds. (These	amour	nts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1		<u></u>					
	-	(2) Claim reserves	•	•			9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n					. 9e		
10		nexperience-rated contracts:			• (_) -,		.,		
							. 10a		72889
	retention of the contract or policy, other than reported in Part I, item 2 above, report amount								
	Sp	pecify nature of costs							
	Sμ	ecity nature of costs							

X No

Yes

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Provision of Information

Part IV

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

nursuant to EDICA continu 102(a)(2)						nspection			
For calendar plan year 2010 or fiscal plan year beginning 06/01/2010 and ending 05/3									
A Name of plan TOTAL BANK FLEXIBLE	BENEFITS PL	AN	1	B Three- plan n	digit umber (P	N) •	501		
C Plan sponsor's name as shown on line 2a of Form 5500. TOTAL BANK D Employer Identification Number (EIN) 59-1498440									
on a separat	on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance can AETNA BEHAVIORAL HE									
	(c) NAIC	(d) Contract or	(e) Approximate num	ber of		Policy or co	ntract year		
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To		
20-0446713	95590	851527	390		06/01/20	010	05/31/2011		
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.									
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all pe	ersons).					
	(a) Name a	and address of the agent, broker	, or other person to whom	commissio	ns or fees	s were paid			
(b) Amount of sales ar	nd base	Fe	es and other commissions	paid					
commissions pai		(c) Amount	(d) Purpose				(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
(b) Amount of sales ar	nd base	Fe	es and other commissions	paid					
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for	nurnoses of
		this report.	iddai comiacis will ea	on ourner may be treated as a drill for	parposos or
4 (Curre	ent value of plan's interest under this contract in the general account at year	end		
5 (Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Conti	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		60	
		Specify nature of costs			
	е	Type of contract: (1) individual policies	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check born	▶ □	
7 /		racts With Unallocated Funds (Do not include portions of these contracts ma		r 📙	
			intained in separate a ite participation guarai		
	а	· / 🕒 · · · · · · · · · · · · · · · · · ·		nee	
		(3) guaranteed investment (4) other			
		Balance at the end of the previous year		7b	
		Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions			C
		Total of balance and additions (add b and c(6))		7d	C
		Deductions:	70(4)		
		(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			
		(4) Other (specify below)	. 7e(4)		
		•			
		(5) Total deductions			С
	f	Balance at the end of the current year (subtract e(5) from d)		7f	0

Page	4

Part 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 v	oup of employees of the surposes if such contracts	are experienc	ce-rated as a unit. W	here contrac			
8 Ben	efit and contract type (check all applicable boxes)	·		<u> </u>	· ·	_		
а	Health (other than dental or vision)	b Dental	сГ	Vision		d ☐ Life insurance		
L	Temporary disability (accident and sickness)	_	<u> </u>	J 1	mploymont	h Prescription drug		
e [·	1	прюуттети			
1 [Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract		
m	Other (specify) EAP							
	erience-rated contracts:		2 (4)					
а	Premiums: (1) Amount received		9a(1)					
	(2) Increase (decrease) in amount due but unpaid					_		
	(3) Increase (decrease) in unearned premium res		9a(3)		0=/4)	0		
L	(4) Earned ((1) + (2) - (3))				9a(4)	0		
р	Benefit charges (1) Claims paid		:-:					
	(2) Increase (decrease) in claim reserves				06/2)	0		
	(3) Incurred claims (add (1) and (2))				9b(3) 9b(4)			
•	(4) Claims charged				30(4)			
С	(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	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							
	(2) Claim reserves							
	(3) Other reserves				2 1/2)			
е								
10 No	nexperience-rated contracts:							
а	Total premiums or subscription charges paid to c	arrier			10a			
b	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							
Sp	ecify nature of costs							
Part I	/ Provision of Information							
11 Did	I the insurance company fail to provide any inform	ation necessary to comp	ete Schedule	A?	Yes	X No		

Department of the Treasury Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 06/01/2010	and ending 05/31/20	11
A Name of plan TOTAL BANK FLEXIBLE BENEFITS PLAN	B Three-digit plan number (PN)	501
	_	
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification	Number (EIN)
TOTAL BANK	59-1498440	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the inform or more in total compensation (i.e., money or anything else of monetary value) in corplan during the plan year. If a person received only eligible indirect compensation for answer line 1 but are not required to include that person when completing the remains	nnection with services rendered to the or which the plan received the require	plan or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Comp		
a Check "Yes" or "No" to indicate whether you are excluding a person from the remain		
indirect compensation for which the plan received the required disclosures (see instr	uctions for definitions and conditions)	Yes No
b If you answered line 1a "Yes," enter the name and EIN or address of each person preceived only eligible indirect compensation. Complete as many entries as needed (he service providers who
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect co	ompensation
(b) Enter name and EIN or address of person who provided	Lyou disclosure on aligible indirect co	mnensation
(b) Liner hame and Linvoi address of person who provided	you disclosure on engine maneet co	mpensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect co	ompensation
(b) Enter name and EIN or address of parson who provided	vou disclosures en cliaible indirect es	emponentian
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect co	ompensauon

	Schedule C (Form 5500) 2010	Page 2-	
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
1	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	irect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	irect compensation

Page 3		3
--------	--	---

answered	d "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in to	otal compensation
			a) Enter name and EIN or	address (see instructions)		
AETNA BE	EHAVIORAL HEALTH,		151 FARN RS32	MINGTON AVENUE RD, CT 06156		
20-044671	3					
(b) Service Code(s)	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?	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?
14	PLAN ADMINISTRATOR	7580	Yes No X	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)	,	
(b) Service Code(s)	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?	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?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	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?	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?
			Yes No	Yes No		Yes No

	Schedule C (Form 5500) 2010			Page 4-		
		(a) Enter name and EIN or	address (see instructions)		
		`	<u>.,</u>			
(b) Service Code(s)	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?	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?
			Yes No	Yes No		Yes No No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	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?	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?
			Yes No	Yes No		Yes No
(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or	Enter direct compensation paid by the plan. If none,	(e) Did service provider receive indirect compensation? (sources	(f) Did indirect compensation include eligible indirect compensation, for which the	Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of

other than plan or plan

sponsor)

Yes No

plan received the required

disclosures?

Yes No

person known to be

a party-in-interest

enter -0-.

eligible indirect

compensation for which you answered "Yes" to element

(f). If none, enter -0-.

an amount or

estimated amount?

Yes No

Part I Service Provider Information (continued)		
3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment may questions for (a) each source from whom the service provider received \$1,000 or more in increase provider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	anagement, broker, or recordkeepindirect compensation and (b) each so	g services, answer the following burce for whom the service
(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 the indirect compensation.
(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 the indirect compensation.
(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 the indirect compensation.

Page **5-**

Schedule C (Form 5500) 2010

Page 6-	1
---------	---

Part II Service Providers Who Fail or Refuse to Provide Information			
4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.			
(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	

Schedule C (Form 5500) 2010	

Page	7-1	

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			Actuaries (see instructions)
а	Name:	·	b EIN:
С	Positio	n:	
d	Addres	s:	e Telephone:
Ex	planatior	:	
a	Name:		b EIN:
C	Positio	n:	
d	Addres		e Telephone:
Fx	planatior	<u> </u>	
_^	₋	-	
а	Name:		b EIN:
c	Positio	n:	
d	Addres		e Telephone:
			•
Ex	planatior	:	
а	Name:		b EIN;
С	Positio	n:	
d	Addres		e Telephone:
Ex	planatior	:	
<u>a</u>	Name:		b EIN;
С	Positio		
d	Addres	s:	e Telephone:
Ex	planatior	i.	