Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2010

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 10/01/2010 and ending 09/30/2011

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [ ] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
CONSTANT CARE MANAGEMENT COMPANY EMPLOYEE LIFE AND ADD BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 10/01/2006

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

545 EAST JOHN CARPENTER FREEWAY,
SUITE 500
IRVING, TX 75062

2b Employer Identification Number (EIN) 38-3254287

2c Sponsor's telephone number 214-845-4500

2d Business code (see instructions) 531390

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.	04/18/2012	CHAD ANDERSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
CONSTANT CARE MANAGEMENT COMPANY DBA CONSTANT CARE FAMILY MANAGEMENT

545 EAST JOHN CARPENTER FREEWAY,
SUITE 500
IRVING, TX 75062

3b Administrator's EIN
38-3254287

3c Administrator's telephone number
214-845-4500

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name
CONSTANT CARE MANAGEMENT

4b EIN
38-3254287

4c PN
502

5	Total number of participants at the beginning of the plan year	**5**	289
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	337
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	337
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1)		**R** (Retirement Plan Information)
(2)		**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)		**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)			**H** (Financial Information)
(2)			**I** (Financial Information – Small Plan)
(3)	X	2	**A** (Insurance Information)
(4)			**C** (Service Provider Information)
(5)			**D** (DFE/Participating Plan Information)
(6)			**G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

For calendar plan year 2010 or fiscal plan year beginning 10/01/2010 and ending 09/30/2011

A Name of plan
CONSTANT CARE MANAGEMENT COMPANY EMPLOYEE LIFE AND ADD BENEFIT PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500.
CONSTANT CARE MANAGEMENT COMPANY DBA CONSTANT CARE FAMILY MANAGEMENT

D Employer Identification Number (EIN)
38-3254287

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
UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	94676/94677	78	10/01/2010	09/30/2011

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
4973	498

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
MEDCON BENEFIT SYSTEMS GROUP, INC.
12400 COIT ROAD, SUITE 1040
DALLAS, TX 75251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4536	498	ADDITIONAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
PLUMHOFF AND ASSOCIATES, INC.
1220 AUGUSTA DRIVE, SUITE 300
HOUSTON, TX 77057

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	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			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

Part III Welfare Benefit Contract Information

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

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

9 Experience-rated contracts:				
a 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)**	
c 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 retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	37779
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 ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

For calendar plan year 2010 or fiscal plan year beginning 10/01/2010 and ending 09/30/2011

A Name of plan
CONSTANT CARE MANAGEMENT COMPANY EMPLOYEE LIFE AND ADD BENEFIT PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500.
CONSTANT CARE MANAGEMENT COMPANY DBA CONSTANT CARE FAMILY MANAGEMENT

D Employer Identification Number (EIN)
38-3254287

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
UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	R0140996	277	10/01/2010	07/31/2011

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
671	73

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
MEDCON BENEFIT SYSTEMS GROUP, INC.
12400 COIT ROAD, SUITE 1040
DALLAS, TX 75251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
671	73	ADDITIONAL COMPENSATION	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 commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	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			**7c(6)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
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			**7e(5)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

Part III Welfare Benefit Contract Information

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

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

9 Experience-rated contracts:				
a 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)**	
c 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 retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	6710
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 ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2010

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 10/01/2010 and ending 09/30/2011

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 than 12 months).

C If the plan is a collectively-bargained plan, check here. ▶ ☐

D Check box if filing under: ☐ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan Constant Care Management Company Employee Life and ADD Benefit Plan

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 10/01/2006

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

545 East John Carpenter Freeway,
Suite 500
Irving TX 75062

2b Employer Identification Number (EIN) 38-3254287

2c Sponsor's telephone number (214)845-4500

2d Business code (see instructions) 531390

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

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

SIGN HERE	[signature]	4/12/12	Chad Anderson
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") SAME	**3b** Administrator's EIN **3c** Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: **a** Sponsor's name Constant Care Management	**4b** EIN 38-3254287	
	4c PN 502	

5 Total number of participants at the beginning of the plan year	5	289
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
a Active participants	6a	337
b Retired or separated participants receiving benefits	6b	0
c Other retired or separated participants entitled to future benefits	6c	0
d Subtotal. Add lines 6a, 6b, and 6c	6d	337
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

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

4B 4F 4L

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[X] Insurance	(1)	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	(2)	[ ] Code section 412(e)(3) insurance contracts
(3)	[ ] Trust	(3)	[ ] Trust
(4)	[ ] General assets of the sponsor	(4)	[ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules		**b General Schedules**		
(1)	[ ] R (Retirement Plan Information)	(1)	[ ]	H (Financial Information)
(2)	[ ] MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2)	[ ]	I (Financial Information – Small Plan)
		(3)	[X] 2	A (Insurance Information)
		(4)	[ ]	C (Service Provider Information)
(3)	[ ] SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5)	[ ]	D (DFE/Participating Plan Information)
		(6)	[ ]	G (Financial Transaction Schedules)