Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN

HERE

SIGN **HERE**

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

| | | <u> </u> | | | Inspection | | | | |
|-----------------|--|---|----------------|--|---|-------|--|--|--|
| Part I | Annual Report Iden | tification Information | | | | | | | |
| For caler | ndar plan year 2010 or fiscal p | | | and ending 12/31/2 | 010 | | | | |
| A This r | eturn/report is for: | a multiemployer plan; | a multiple | e-employer plan; or | | | | | |
| | | a single-employer plan; | ☐ a DFE (s | pecify) | | | | | |
| | | | | | | | | | |
| B This r | eturn/report is: | the first return/report; | the final i | return/report; | | | | | |
| | • | 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; | | c extension; | the DFVC program; | | | | |
| | , and the second | special extension (enter des | scription) | | | | | | |
| Part l | I Basic Plan Inforn | nation—enter all requested informa | ation | | | | | | |
| 1a Nam | e of plan | | | | 1b Three-digit plan | 501 | | | |
| MOELIS | & COMPANY HOLDINGS H | EALTH & WELFARE PLAN | | | number (PN) ▶ | | | | |
| | | | | | 1c Effective date of plants of plants of plants of the original of the origi | an | | | |
| 2a Plan | sponsor's name and address | s (employer, if for a single-employer p | plan) | | 2b Employer Identifica | ition | | | |
| , | ress should include room or s | uite no.) | | | Number (EIN) 20-8980370 | | | | |
| MOELIS | & COMPANY HOLDINGS | | | | 2c Sponsor's telephor | | | | |
| | | | | | number | | | | |
| 000 DAD | L ANGENIE | | | | 212-883-3895 | | | | |
| 5TH FLC | K AVENUE OOR | 399 PARK 5TH FLOO | (AVENUE OR | | 2d Business code (see | е | | | |
| NEW YC | PRK, NY 10022 | NEW YOR | RK, NY 10022 | | instructions) | | | | |
| | | | | | 551111 | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | 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 | Filed with authorized/valid ele | ectronic signature. | 10/09/2012 | MEGAN SPARGO | | | | | |
| HERE | Signature of plan adminis | trator | Date | Enter name of individual signing as plan admin | | | | | |
| | - | | | | • | | | | |

10/09/2012

Date

Date

MEGAN SPARGO

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

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

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of DFE

Form 5500 (2010) v.092307.1

Form 5500 (2010) Page **2**

| | Plan administrator's name and address (if same as plan sponsor, enter "San | ne") | | ministrator's EIN 8980370 |
|---------|---|---|--|---|
| 5T | PARK AVENUE H FLOOR W YORK, NY 10022 | | nu | ministrator's telephone mber 2-883-3895 |
| | | | | |
| 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 | 235 |
| 6 | Number of participants as of the end of the plan year (welfare plans complete | e only lines 6a, 6b, 6c, and 6d). | | I |
| а | Active participants | | . 6a | 282 |
| b | Retired or separated participants receiving benefits | | . 6b | 1 |
| С | Other retired or separated participants entitled to future benefits | | . 6c | 2 |
| d | Subtotal. Add lines 6a, 6b, and 6c | | . 6d | 285 |
| е | Deceased participants whose beneficiaries are receiving or are entitled to re | ceive benefits | . 6е | 0 |
| f | Total. Add lines 6d and 6e | | . 6f | 285 |
| g | Number of participants with account balances as of the end of the plan year complete this item) | • | . 6g | 0 |
| h | Number of participants that terminated employment during the plan year with less than 100% vested | | . 6h | 0 |
| 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 4Q | | | |
| 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) Insurance (2) Code section 412(e)(3) (3) Trust (4) General assets of the sp | 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 9 A (Insurance Inform (4) C (Service Provide (5) D (DFE/Participati | mation) nation — i mation) er Inform ng Plan | Small Plan) nation) 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.

OMB No. 1210-0110

| Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | | | | | rm is Open to Public Inspection | | | | |
|---|------------------|--------------------------------------|---|--------------------------|------------------------------------|--|--|--|--|
| For calendar plan year 20 | 10 or fiscal pla | n year beginning 01/01/2010 | and e | nding 12/31/2010 | | | | | |
| A Name of plan MOELIS & COMPANY H | OLDINGS HEA | ALTH & WELFARE PLAN | | e-digit number (PN) | 501 | | | | |
| C Plan sponsor's name a MOELIS & COMPANY H | (EIN) | | | | | | | | |
| 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 ca | | RANCE COMPANY AND AFFILIA | | | | | | | |
| (b) EIN | (c) NAIC | (d) Contract or | (e) Approximate number of persons covered at end of | Policy or o | contract year | | | | |
| (6) EIN | code | identification number | policy or contract year | (f) From | (g) To | | | | |
| 06-0303370 | 62308 | 3332833 | 297 | 01/01/2010 | 12/31/2010 | | | | |
| 2 Insurance fee and com descending order of the | | ation. Enter the total fees and tota | Il commissions paid. List in item 3 | the agents, brokers, and | other persons in | | | | |
| (a) Total | amount of com | missions paid | (b) To | otal amount of fees paid | | | | | |
| | | 118120 | | | 9110 | | | | |
| 3 Persons receiving com | missions and f | ees. (Complete as many entries a | as needed to report all persons). | | | | | | |
| | | and address of the agent, broker, of | | ions or fees were paid | | | | | |
| FRANK CRYSTAL & CO | | 32 OL | D SLIP | | | | | | |
| | | FL 17 NEW \ | YORK, NY 10005-3557 | | | | | | |
| (b) Amount of sales a | nd base | Fees | s and other commissions paid | | | | | | |
| commissions pa | id | (c) Amount | (d) Purpos | e | (e) Organization code | | | | |
| | 118120 | 9110 INC | CENTIVE COMPENSATION | | 3 | | | | |
| | (a) Name a | and address of the agent, broker, o | or other person to whom commiss | ions or fees were paid | | | | | |
| | (4) | | | , | | | | | |
| (In) Assault (1) | | Fee | s and other commissions paid | | | | | | |
| (b) Amount of sales a commissions pa | | (c) Amount | (d) Purpos | e | (e) Organization code | | | | |
| | | | | | | | | | |
| | A 4 NI 41 | LOND O 4 IN I | 4 1 4 4 6 5 5500 | | | | | | |

| 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 |
| | | | | |
| | | | | |

| Pá | art II | Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report. | ridual contracts | with each carrier may be | treated | d as a unit for purposes of |
|----|--------|--|-------------------|--------------------------|---------|-----------------------------|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year e | | | 5 | 0 |
| _ | | racts With Allocated Funds: | | • | u | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
| | |

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

Part III

Welfare Benefit Contract Information

| | | the entire group of such individual contracts v | | | | | | | | is cover individual emplo | byees, |
|----|------|--|---------|-------------|-------------|-----------|-----|-------------------|--------------------|---------------------------|--------|
| 8 | Ben | efit and contract type (check all applicable boxes) | | | - | | | · | | | |
| | а | Health (other than dental or vision) | b | Dental | | | с | Vision | | d Life insurance | |
| | е | Temporary disability (accident and sickness) | f | Long-terr | n disabilit | V | g | Supplemental unem | ployment | h Prescription drug | |
| | i Ì | Stop loss (large deductible) | ιÌ | HMO con | | | k [| PPO contract | | I Indemnity contract | t |
| | m | Other (specify) | , , | | | | |] | | | • |
| | L | _ Caron (openity) / | | | | | | | | | |
| 9 | Ехр | erience-rated contracts: | | | | | | | | | |
| | | Premiums: (1) Amount received | | | | 9a(1 |) | | 0 | | |
| | | (2) Increase (decrease) in amount due but unpaid | ١ | | | 9a(2 |) | | 0 | | |
| | | (3) Increase (decrease) in unearned premium res | erve |) | | 9a(3 |) | | 0 | | |
| | | (4) Earned ((1) + (2) - (3)) | | | Г | | | | 9a(4) | | 0 |
| | b | Benefit charges (1) Claims paid | | | f | 9b(1 | | | 0 | | |
| | | (2) Increase (decrease) in claim reserves | | | - | • | | | | | 0 |
| | | (3) Incurred claims (add (1) and (2))(4) Claims charged | | | | | | | 9b(3) 9b(4) | | 0 |
| | С | Remainder of premium: (1) Retention charges (o | | | | | | | 3D(1) | | |
| | Ū | (A) Commissions | | | T T | 9c(1)(| A) | | 0 | | |
| | | (B) Administrative service or other fees | | | F | 9c(1)(| | | 0 | | |
| | | (C) Other specific acquisition costs | | | H | 9c(1)(| | | 0 | | |
| | | (D) Other expenses | | | | 9c(1)(| D) | | 0 | | |
| | | (E) Taxes | | | F- | 9c(1)(| | | 0 | | |
| | | (F) Charges for risks or other contingencies | | | | 9c(1)(| F) | | 0 | | |
| | | (G) Other retention charges | | | | 9c(1)(| G) | | 0 | | |
| | | (H) Total retention | | - | _ | | _ | | | | 0 |
| | | (2) Dividends or retroactive rate refunds. (These | | | | | _ | | | | 0 |
| | d | Status of policyholder reserves at end of year: (1 | | | • | | | | 9d(1) | | 0 |
| | | (2) Claim reserves | | | | | | | 9d(2) | | 0 |
| | _ | (3) Other reserves | | | | | | | 9d(3) | | 0 |
| 10 | No | Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts: | אנ וווו | ciude amour | it entered | III C(2). |) | | 9e | | |
| | a | Total premiums or subscription charges paid to c | arrie | er | | | | | 10a | 2 | 362396 |
| | b | If the carrier, service, or other organization incurr | | | | | | | 100 | | |
| | | retention of the contract or policy, other than repo | | | | | | • | 10b | | 0 |
| | Sp | pecify nature of costs | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Pa | rt I | V 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

| pursuant to ERISA section 103(a)(2). | | | | orm is Open to Public Inspection | | | | | |
|---|------------------|---------------------------------------|---|-------------------------------------|-----------------------|--|--|--|--|
| For calendar plan year 20 | 10 or fiscal pla | n year beginning 01/01/2010 | and er | nding 12/31/2010 | | | | | |
| A Name of plan MOELIS & COMPANY H | OLDINGS HE | ALTH & WELFARE PLAN | | e-digit number (PN) | 501 | | | | |
| C Plan sponsor's name a MOELIS & COMPANY H | | ne 2a of Form 5500. | D Emplo 20-898 | yer Identification Number | (EIN) | | | | |
| 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 ca | | RANCE COMPANY | | | | | | | |
| (b) FINI | (c) NAIC | (d) Contract or | (e) Approximate number of | Policy or | contract year | | | | |
| (b) EIN | code | identification number | persons covered at end of policy or contract year | (f) From | (g) To | | | | |
| 06-0303370 | 62308 | 04520A | 8 | 01/01/2010 | 12/31/2010 | | | | |
| 2 Insurance fee and com descending order of the | | nation. Enter the total fees and tota | I commissions paid. List in item 3 | the agents, brokers, and | other persons in | | | | |
| (a) Total | amount of com | nmissions paid | (b) To | otal amount of fees paid | | | | | |
| | | 6131 | | | 0 | | | | |
| 3 Persons receiving com | missions and | fees. (Complete as many entries a | as needed to report all persons). | | | | | | |
| | | and address of the agent, broker, o | | ions or fees were paid | | | | | |
| FRANK CRYSTAL & CO. | | 32 OLI | OSLIP | | | | | | |
| | | FL 17 NEW 1 | ORK, NY 10005 | | | | | | |
| (b) Amount of sales a | nd base | Fees | and other commissions paid | | | | | | |
| commissions pa | | (c) Amount | (d) Purpose | Э | (e) Organization code | | | | |
| | 6131 | 0 | | | 3 | | | | |
| | (a) Name | and address of the agent, broker, o | or other person to whom commissi | ions or fees were paid | | | | | |
| | (w) Hairio | and address of the agent, broker, t | caor porcon to whom commissi | or root word paid | | | | | |
| | | | | | | | | | |
| (b) Amount of sales a | nd hase | Fees | and other commissions paid | | | | | | |
| commissions pa | | (c) Amount | (d) Purpose | e | (e) Organization code | | | | |
| | | | | | | | | | |
| | | 101100 | | | /= ===== | | | | |

| 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 |
| | | | | |
| | | | | |

| Pá | art II | Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report. | ridual contracts | with each carrier may be | treated | d as a unit for purposes of |
|----|--------|--|-------------------|--------------------------|---------|-----------------------------|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year e | | | 5 | 0 |
| _ | | racts With Allocated Funds: | | • | u | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
| | |

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.

Welfare Benefit Contract Information

Part III

| 8 | 3ene | fit and contract type (check all applicable boxes) | | | | | |
|-----|-------|--|------------------------------|-------------------|---------------------|-----------------|------------------------|
| | a 🏻 | Health (other than dental or vision) | b X Dental | С | Vision | c | Life insurance |
| | e 🗍 | Temporary disability (accident and sickness) | f Long-term disability | · g | Supplemental unempl | oyment h | Prescription drug |
| | iΓ | Stop loss (large deductible) | j HMO contract | k | PPO contract | | I X Indemnity contract |
| | m X | = 1/4 0114 = 1011 | , | |] | , | |
| , | | Other (specify) | | | | | |
| 9 F | yne | rience-rated contracts: | | | | | |
| | • | Premiums: (1) Amount received | Γ | 9a(1) | | 0 | |
| | | (2) Increase (decrease) in amount due but unpaid | <u> </u> | 9a(2) | | 0 | |
| | | (3) Increase (decrease) in unearned premium rese | | 9a(3) | | 0 | |
| | | (4) Earned ((1) + (2) - (3)) | <u> </u> | | | 9a(4) | 0 |
| | | Benefit charges (1) Claims paid | | | | 0 | |
| | | (2) Increase (decrease) in claim reserves | - | | | 0 | |
| | | (3) Incurred claims (add (1) and (2)) | _ | | | 9b(3) | 0 |
| | | (4) Claims charged | | | - | 9b(4) | 0 |
| | | Remainder of premium: (1) Retention charges (or | | | _ | . , | |
| | | (A) Commissions | [′] | 9c(1)(A) | | 0 | |
| | | (B) Administrative service or other fees | | | | 0 | |
| | | (C) Other specific acquisition costs | | 9c(1)(C) | | 0 | |
| | | (D) Other expenses | | 9c(1)(D) | | 0 | |
| | | (E) Taxes | | 9c(1)(E) | | 0 | |
| | | (F) Charges for risks or other contingencies | | 9c(1)(F) | | 0 | |
| | | (G) Other retention charges | | 9c(1)(G) | | 0 | |
| | | (H) Total retention | | | | 9c(1)(H) | 0 |
| | | (2) Dividends or retroactive rate refunds. (These | amounts were 🗌 paid in | cash, or | credited.) | 9c(2) | 0 |
| | d | Status of policyholder reserves at end of year: (1) | Amount held to provide b | enefits after | retirement | 9d(1) | 0 |
| | | (2) Claim reserves | | | | 9d(2) | 0 |
| | | (3) Other reserves | | | | 9d(3) | 0 |
| | е | Dividends or retroactive rate refunds due. (Do no | t include amount entered | in c(2) .) | | 9e | 0 |
| 10 | Nor | nexperience-rated contracts: | | | - | | |
| | а | Total premiums or subscription charges paid to ca | ırrier | | | 10a | 61312 |
| | | If the carrier, service, or other organization incurre | , , | | ' | 401 | 0 |
| | | retention of the contract or policy, other than repo | rted in Part I, item 2 above | e, report amo | ount | 10b | |
| | Sp | ecify nature of costs | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Pa | rt IV | Provision of Information | | | | | |
| 11 | Did | the insurance company fail to provide any informa | ation necessary to comple | te Schedule | A? | Yes X | No |
| 12 | If th | te answer to line 11 is "Yes " specify the information | on not provided | | | | |

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

| = | | | | | m is Open to Public Inspection | | | |
|---|--|--------------------------|--------------------------|---|-----------------------------------|-----------------------|------------------|--------------------------------|
| For calendar plan year 20 | 10 or fiscal plar | n year beginning | 01/01/2010 | | and er | nding 12 | /31/2010 | |
| A Name of plan MOELIS & COMPANY He | OLDINGS HEA | LTH & WELFARE PI | _AN | | | e-digit number (PI | N) • | 501 |
| | | | | | | | | |
| C Plan sponsor's name a MOELIS & COMPANY He | | e 2a of Form 5500. | | | D Emplo 20-898 | | ation Number (| EIN) |
| | | | | overage, Fees, a unit in Parts II and III | | | | nation for each contract A. |
| 1 Coverage Information: | | | | | | | | |
| (a) Name of insurance ca | | DMPANY | | | | | | |
| /b) [IN] | (c) NAIC | (d) Contra | ct or | (e) Approximate no | | | Policy or co | ontract year |
| (b) EIN | code | identification | number | persons covered a policy or contrac | | (f) | From | (g) To |
| 13-5581829 | 65978 | TM05751973 | | 63 | 37 | 01/01/20 | 110 | 12/31/2010 |
| 2 Insurance fee and com descending order of the | | ation. Enter the total f | ees and tota | l commissions paid. L | ist in item 3 | the agents, | , brokers, and c | other persons in |
| (a) Total a | (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | | | |
| | | | 4635 | | | | | 3383 |
| 3 Persons receiving com | missions and fe | ees. (Complete as m | any entries a | as needed to report all | persons). | | | |
| | | | | or other person to who | | ions or fees | were paid | |
| FRANK CRYSTAL & CO | INC | | 32 OLI FL 17 NEW Y | D SLIP YORK, NY 10005-3557 | , | | | |
| (b) Amount of sales ar | nd base | | Fees | s and other commission | ns paid | | | |
| commissions pa | | (c) Amount | | | (d) Purpose | | | (e) Organization code |
| | 4635 | | 3383 SU | PPLEMENTAL COMP | ENSATION | | | 3 |
| | (a) Name a | nd address of the ag | ent, broker, o | or other person to who | m commiss | ions or fees | were paid | |
| | | | | | | | | |
| (b) Amount of sales ar | nd hase | | Fees | s and other commission | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | | | | (e) Organization code |
| For Panerwork Reduction | un Act Notice a | and OMB Control No | imhers see | the instructions for E | Form 5500 | | Sch | edule 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 | | 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 indivithis report. | pe treated as a unit for purposes of | | | |
|---------|---|--|--------------------------------------|-----------------|------|---|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | Current value of plan's interest under this contract in separate accounts at year end | | | | | 0 |
| _ | Contracts With Allocated Funds: | | | | | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
| | |

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.

Part III

Welfare Benefit Contract Information

| 8 | Bene | efit and contract type (check all applicable boxes) | | | | | | |
|----|-------|--|----------------------|--------------------------------|----------------|-----------------|-----|--------------------|
| | а | Health (other than dental or vision) | b X Dental | c | Vision | | d | Life insurance |
| | е | Temporary disability (accident and sickness) | f Long-tern | n disability Q | Supplement | al unemployment | h | Prescription drug |
| | ιĒ | Stop loss (large deductible) | j HMO con | tract k | PPO contrac | ct | ıĪ | Indemnity contract |
| | m | Other (specify) | • 🗆 | | | | - L | _ |
| | | _ earer (epoonly) | | | | | | |
| 9 | Ехре | erience-rated contracts: | | | | | | |
| | a F | Premiums: (1) Amount received | | 9a(1) | | | 0 | |
| | | (2) Increase (decrease) in amount due but unpaid | | | | | 0 | |
| | | (3) Increase (decrease) in unearned premium rese | erve | 9a(3) | | | 0 | |
| | | (4) Earned ((1) + (2) - (3)) | | | | 9a(4) | | 0 |
| | - | Benefit charges (1) Claims paid | | | | | 0 | |
| | | (2) Increase (decrease) in claim reserves | | 9b(2) | | | 0 | |
| | | (3) Incurred claims (add (1) and (2)) | | | | 9b(3) | | 0 |
| | | (4) Claims charged | | | | 9b(4) | | 0 |
| | С | Remainder of premium: (1) Retention charges (or | n an accrual bas | is) | | ' | | |
| | | (A) Commissions | | 9c(1)(A |) | | 0 | |
| | | (B) Administrative service or other fees | | | | | 0 | |
| | | (C) Other specific acquisition costs | | 9c(1)(C |) | | 0 | |
| | | (D) Other expenses | | 9c(1)(D |) | | 0 | |
| | | (E) Taxes | | 9c(1)(E | | | 0 | |
| | | (F) Charges for risks or other contingencies | | 9c(1)(F) | | | 0 | |
| | | (G) Other retention charges | | 9c(1)(G |) | | 0 | |
| | | (H) Total retention | | | | 9c(1)(H | 1) | 0 |
| | | (2) Dividends or retroactive rate refunds. (These | amounts were | paid in cash, or | credited.) | 9c(2) | | 0 |
| | d | Status of policyholder reserves at end of year: (1) | Amount held to | provide benefits at | ter retirement | | | 0 |
| | | (2) Claim reserves | | | | 9d(2) | | 0 |
| | | (3) Other reserves | | | | 9d(3) | | 0 |
| | е | Dividends or retroactive rate refunds due. (Do no | t include amoun | nt entered in c(2) .) . | | 9e | | 0 |
| 10 | Noi | nexperience-rated contracts: | | | | | | |
| | а | Total premiums or subscription charges paid to ca | arrier | | | 10a | | 186421 |
| | | If the carrier, service, or other organization incurre | | | • | | | 0 |
| | | retention of the contract or policy, other than repo | orted in Part I, ite | em 2 above, report a | ımount | 10b | L_ | |
| | Sp | ecify nature of costs | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Pa | rt I\ | / Provision of Information | | | | | | |
| 11 | | the insurance company fail to provide any inform | ation necessary | to complete Sched | ıle A? | Yes | X | No |
| | | | | | ло д: | Ш . 33 | | |
| 12 | if th | ne answer to line 11 is "Yes," specify the information | on not provided. | • | | | | |

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

| For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010 A Name of plan Number (PN) | | | | | m is Open to Public Inspection | | |
|--|---------------------------|------------------|--------------------------------------|---------------------------------|-----------------------------------|----------------|-----------------------|
| C Plan sponsor's name as shown on line 2a of Form 5500. Part 1 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 COMPANION LIFE INSURANCE COMPANY (b) EIN (c) NAIC odde identification number persons covered at end of policy or contract year persons covered at end of policy or contract year (g) Approximate number of persons covered at end of policy or contract year persons covered at end of policy or contract year (g) To 13-1595128 (2243 GLCLOAEX4 2244 01/01/2010 12/31/2010 12/ | For calendar plan year 20 | 10 or fiscal pla | n year beginning 01/01/2010 | ar | d ending 12 | 2/31/2010 | |
| 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 COMPANION LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year identification number policy or contract year identification number in policy or contract year identification number in policy or contract year policy or contract year policy or contract year in the policy or contract year policy or contract year in the policy | | OLDINGS HEA | LTH & WELFARE PLAN | | Ū | N) • | 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 COMPANION LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year identification number policy or contract year (i) From (g) To 13-1595128 (6243) GLCL0AEX4 244 01/01/2010 12/31/2010 12/31/2010 13-1595128 (a) Total amount of commissions paid (b) Total amount of tees paid 0. (a) Total amount of commissions paid (b) Total amount of tees paid 0. 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 0. (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 0. (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 0. (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 0. (b) Amount of sales and base Fees and other commissions paid (e) Organization code 0. | | | | | | | |
| no 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 COMPANION LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number of identification number of persons covered at end of policy or contract year (g) To 13-1695128 62243 GLCLOAEX4 244 01/01/2010 12/31/2010 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 2550 0 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 FRANK CRYSTAL & CO INC. 12 OLD SLIP FL 17 NEW YORK, NY 10005-3557 (b) Amount of sales and base Commissions paid (c) Amount (d) Purpose (e) Organization code 3 Old 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 | | | e 2a of Form 5500. | | | cation Number | (EIN) |
| (a) Name of insurance carrier COMPANION LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number of identification number of 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 (y) From (g) To 13-1595128 62243 GLCLOAEX4 244 01/01/2010 12/31/2010 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 2550 0 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 FRANK CRYSTAL & CO INC. FLT FLT NEW YORK, NY 10005-3557 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 2550 0 (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 (c) Amount of sales and base Fees and other commissions or fees were paid | | | | | | | |
| (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 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 year at end of year of the person 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 of commissions 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 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 2550 0 0 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid | 1 Coverage Information: | | | | | | |
| (b) EIN (c) NATIC CORD identification number persons covered at end of policy or contract year or | ` ' | | PANY | | | | |
| 13-1595128 62243 GLCLOAEX4 244 01/01/2010 12/31/2010 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 2550 0 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 FRANK CRYSTAL & CO INC. (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 2550 0 (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 (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) EIN | | | | | | |
| 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 2550 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 FRANK CRYSTAL & CO INC. 132 OLD SLIP FL 17 NEW YORK, NY 10005-3557 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 2550 0 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid | | code | identification number | | (f) | From | (g) 10 |
| descending order of the amount paid. (a) Total amount of commissions paid 2550 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 FRANK CRYSTAL & CO INC. 32 OLD SLIP FL 17 NEW YORK, NY 10005-3557 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 2550 3 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 | 13-1595128 | 62243 | GLCL0AEX4 | 244 | 01/01/20 | 010 | 12/31/2010 |
| 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 FRANK CRYSTAL & CO INC. 32 OLD SLIP FL 17 NEW YORK, NY 10005-3557 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 3 (b) Amount of sales 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 | | | ation. Enter the total fees and tota | l commissions paid. List in ite | m 3 the agents | , brokers, 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 FRANK CRYSTAL & CO INC. 12 OLD SLIP FL 17 NEW YORK, NY 10005-3557 (b) Amount of sales and base | (a) Total a | amount of com | | (k |) Total amount | of fees paid | |
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid FRANK CRYSTAL & CO INC. 32 OLD SLIP FL 17 NEW YORK, NY 10005-3557 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 2550 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid | 3 Persons receiving com | missions and f | | as needed to report all person | s) | | 0 |
| FRANK CRYSTAL & CO INC. 32 OLD SLIP FL 17 NEW YORK, NY 10005-3557 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 2550 0 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 | T crocke receiving com | | | | | were naid | |
| (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 | FRANK CRYSTAL & CO | | 32 OL FL 17 | D SLIP | missions of fees | s were paid | |
| commissions paid (c) Amount (d) Purpose (e) Organization code 2550 0 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 | (b) Amount of sales ar | nd base | Fee | s 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 | (d) Pur | pose | | 1 |
| (b) Amount of sales and base Fees and other commissions paid | | 2550 | 0 | | | | 3 |
| (b) Amount of sales and base | | (a) Name a | and address of the agent, broker, | or other person to whom com | nissions or fees | were paid | |
| (b) Amount of sales and base | | | y , , , | · | | , | |
| | (b) Amount of sales ar | nd base | Fee | s and other commissions paid | | | |
| | | | (c) Amount | (d) Pur | pose | | (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 indivithis report. | pe treated as a unit for purposes of | | | |
|---------|---|--|--------------------------------------|-----------------|------|---|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | Current value of plan's interest under this contract in separate accounts at year end | | | | | 0 |
| _ | Contracts With Allocated Funds: | | | | | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
| | |

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

Part III

Part IV

Welfare Benefit Contract Information

| | | the entire group of such individual contracts | | | | | | s cover individual employees, |
|----|----------|---|-----------------|---------------|------------------|-------------------|----------|-------------------------------|
| 8 | Ben | efit and contract type (check all applicable boxes) | | | | | | |
| | а | Health (other than dental or vision) | b Dental | | c | Vision | | d X Life insurance |
| | е | Temporary disability (accident and sickness) | f Long-ter | m disability | g | Supplemental unem | ployment | h Prescription drug |
| | i | Stop loss (large deductible) | j HMO co | ntract | k | PPO contract | | I Indemnity contract |
| | m | Other (specify) | | | _ | _ | | |
| a | Evne | erience-rated contracts: | | | | | | |
| 9 | | Premiums: (1) Amount received | | Г | 9a(1) | | 0 | |
| | u i | | | | 9a(1) | | 0 | |
| | | (2) Increase (decrease) in amount due but unpaid | | | 9a(2) | | 0 | - |
| | | (3) Increase (decrease) in unearned premium res | | _ | | | 02/4) | 0 |
| | L | (4) Earned ((1) + (2) - (3)) | | | | | . 9a(4) | |
| | b | Benefit charges (1) Claims paid | | | 9b(1) | | 0 | |
| | | (2) Increase (decrease) in claim reserves | | <u> </u> | 9b(2) | | | |
| | | (3) Incurred claims (add (1) and (2)) | | | | | | 0 |
| | | (4) Claims charged | | | | | . 9b(4) | 0 |
| | С | Remainder of premium: (1) Retention charges (c | n an accrual ba | sis) | | | | |
| | | (A) Commissions | | | 9c(1)(A) | | 0 | |
| | | (B) Administrative service or other fees | | | 9c(1)(B) | | 0 | |
| | | (C) Other specific acquisition costs | | | 9c(1)(C) | | 0 | |
| | | (D) Other expenses | | | 9c(1)(D) | | 0 | |
| | | (E) Taxes | | | 9c(1)(E) | | 0 | Ti . |
| | | (F) Charges for risks or other contingencies. | | F- | 9c(1)(F) | | 0 | i i |
| | | (G) Other retention charges | | _ | 9c(1)(G) | | 0 | |
| | | ` ' | | <u> </u> | | | 9c(1)(H) | 0 |
| | | (H) Total retention | | | _ | | | 0 |
| | ٨ | | | | <u> </u> | | | 0 |
| | d | Status of policyholder reserves at end of year: (1 | • | • | | | | 0 |
| | | (2) Claim reserves | | | | | . 9d(2) | 0 |
| | | (3) Other reserves | | | | | . 9d(3) | |
| | е | Dividends or retroactive rate refunds due. (Do n | ot include amou | ınt entered i | n c(2) .) | | 9e | 0 |
| 10 | No | nexperience-rated contracts: | | | | | | |
| | а | Total premiums or subscription charges paid to o | arrier | | | | 10a | 25498 |
| | b | If the carrier, service, or other organization incurretention of the contract or policy, other than rep | | | | | . 10b | 0 |
| | Sn | pecify nature of costs | | | , | | | - |
| | Οþ | recity flature of costs * | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

X No

Yes

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

Provision of Information

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

| pursuant to ERISA section 103(a)(2). | | | | | | m is Open to Public Inspection |
|---|------------------|--|---|-----------------------------|---------------------|-----------------------------------|
| For calendar plan year 20 | 10 or fiscal pla | an year beginning 01/01/2010 | | and ending | 12/31/2010 | • |
| A Name of plan MOELIS & COMPANY He | OLDINGS HE | ALTH & WELFARE PLAN | В | Three-digit plan number | (PN) • | 501 |
| | | | | | | |
| C Plan sponsor's name a MOELIS & COMPANY He | | ne 2a of Form 5500. | D | Employer Iden 20-8980370 | tification Number | (EIN) |
| | | ning Insurance Contract (. Individual contracts grouped as | | | | |
| 1 Coverage Information: | | | | | | |
| (a) Name of insurance ca | | PANY | | | | |
| | (a) NIAIC | (d) Contract or | (e) Approximate numb | er of | Policy or co | ontract year |
| (b) EIN | (c) NAIC code | (d) Contract or identification number | persons covered at er policy or contract ye | | (f) From | (g) To |
| 13-1595128 | 62243 | GCEL0AEX4 | 57 | 01/01 | /2010 | 12/31/2010 |
| 2 Insurance fee and com descending order of the | | nation. Enter the total fees and tot | al commissions paid. List i | n item 3 the age | nts, brokers, and o | other persons in |
| (a) Total a | amount of con | nmissions paid | | (b) Total amou | unt of fees paid | |
| | | 2953 | | | | 0 |
| 3 Persons receiving com | missions and | fees. (Complete as many entries | as needed to report all per | sons). | | |
| | (a) Name | and address of the agent, broker, | or other person to whom c | ommissions or f | ees were paid | |
| FRANK CRYSTAL & CO | INC. | FL 17 | _D SLIP , YORK, NY 10005-3557 | | | |
| (b) Amount of sales ar | nd hase | Fee | es and other commissions p | aid | | |
| commissions pa | | (c) Amount | (d) | Purpose | | (e) Organization code |
| 2953 | | | | | 3 | |
| | (a) Name | and address of the agent, broker, | or other person to whom co | ommissions or fo | ees were paid | |
| | | | | | | |
| (b) Amount of sales ar | nd base | Fee | es and other commissions p | oaid | | |
| commissions pa | | (c) Amount | (d) | Purpose | | (e) Organization code |
| | | | | | | |
| For Paperwork Reduction | n Act Notice | and OMB Control Numbers, see | the instructions for Forn | n 5500 | Sch | edule 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 | | 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 indivithis report. | with each carrier may be | be treated as a unit for purposes of | | |
|---------|-------|--|--------------------------|--------------------------------------|------|---|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year e | | | 5 | 0 |
| _ | | racts With Allocated Funds: | | • | u | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
|------|---|

Welfare Benefit Contract Information

Part III

| | | If more than one contract covers the same gi information may be combined for reporting p the entire group of such individual contracts | urpos | ses if | f such contra | acts a | re experie | nc | e-rated as a unit. Wh | ere contrac | | |
|----|-------|--|--------|--------|----------------|---------|-------------------|----|-----------------------|-------------|----------------------|-------------|
| 8 | Ben | efit and contract type (check all applicable boxes) | | | | | | | | | | |
| | а | Health (other than dental or vision) | b | Тρ | ental | | С | П | Vision | | d X Life insu | ırance |
| | е | Temporary disability (accident and sickness) | f | _ | ong-term dis | abilitv | | H | Supplemental unemp | lovment | h Prescrip | |
| | i È | Stop loss (large deductible) | ιĖ | = | MO contract | • | k | 三 | PPO contract | , | | ty contract |
| | m [| | , _ | | | | • | ш | 11 o contidor | | | ty contract |
| | | Other (specify) | | | | | | | | | | |
| 9 | Exne | erience-rated contracts: | | | | | | | | | | |
| Ŭ | • | Premiums: (1) Amount received | | | | Γ | 9a(1) | | | (| 0 | |
| | | (2) Increase (decrease) in amount due but unpaid | | | | | 9a(2) | | | (| 0 | |
| | | (3) Increase (decrease) in unearned premium res | | | | | | | | (| 0 | |
| | | (4) Earned ((1) + (2) - (3)) | | | | _ | | | | 9a(4) | | 0 |
| | b | Benefit charges (1) Claims paid | | | | | | | | |) | |
| | | (2) Increase (decrease) in claim reserves | | | | | | | | (| 0 | |
| | | (3) Incurred claims (add (1) and (2)) | | | | | | | | 9b(3) | | 0 |
| | | (4) Claims charged | | | | | | | | 9b(4) | | 0 |
| | С | Remainder of premium: (1) Retention charges (c | n an | accı | rual basis) | | | | | | | |
| | | (A) Commissions | | | | | 9c(1)(A) | | | (| 0 | |
| | | (B) Administrative service or other fees | | | | | 9c(1)(B) | | | (| 0 | |
| | | (C) Other specific acquisition costs | | | | | 9c(1)(C) | | | | 0 | |
| | | (D) Other expenses | | | | _ | 9c(1)(D) | _ | | | 0 | |
| | | (E) Taxes | | | | _ | 9c(1)(E) | | | | 0 | |
| | | (F) Charges for risks or other contingencies. | | | | | 9c(1)(F) | | | | 0 | |
| | | (G) Other retention charges | | | | | 9c(1)(G) | | | | 0 | |
| | | (H) Total retention | | | <u></u> | | <u></u> | | | 9c(1)(H |) | 0 |
| | | (2) Dividends or retroactive rate refunds. (These | amo | ounts | s were pa | aid in | cash, or | С | redited.) | 9c(2) | | 0 |
| | d | Status of policyholder reserves at end of year: (1 |) Am | ount | t held to prov | vide b | enefits aft | er | retirement | 9d(1) | | 0 |
| | | (2) Claim reserves | | | | | | | | 9d(2) | | 0 |
| | | (3) Other reserves | | | | | | | | 9d(3) | | 0 |
| | е | Dividends or retroactive rate refunds due. (Do n | ot inc | clude | amount ent | tered | in c(2) .) | | | 9e | | 0 |
| 10 | No | nexperience-rated contracts: | | | | | | | | | | |
| | а | Total premiums or subscription charges paid to o | arrier | r | | | | | | 10a | | 29532 |
| | b | If the carrier, service, or other organization incurretention of the contract or policy, other than rep | | | | | | | • | 10b | | 0 |
| | Sp | ecify nature of costs | | | | | | | | | | |
| | | | | | | | | | | | | |
| Pa | rt I\ | Provision of Information | | | | | | | | | | |

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

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

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.

OMB No. 1210-0110

| pursuant to ERISA section 103(a)(2). This Form is Open to Inspection | | | | | | | |
|---|----------------|------------------------------------|--|-------------------------|-------------------------|--|--|
| For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010 | | | | | | | |
| A Name of plan MOELIS & COMPANY HOLDINGS HEALTH & WELFARE PLAN B Three-digit plan number (PN) | | | | | 501 | | |
| C Plan sponsor's name as shown on line 2a of Form 5500. MOELIS & COMPANY HOLDINGS D Employer Identification Number (EIN) 20-8980370 | | | | | | | |
| | | | Coverage, Fees, and Co s a unit in Parts II and III can be r | | | | |
| 1 Coverage Information: | | | | | | | |
| (a) Name of insurance ca | | MPANY | | | | | |
| <i>a</i> > = | (c) NAIC | (d) Contract or | (e) Approximate number of | Poli | cy or contract year | | |
| (b) EIN | code | identification number | persons covered at end of policy or contract year | (f) From | (g) To | | |
| 47-0246511 | 71412 | GMG 0AEX4 | 183 | 01/01/2010 | 12/31/2010 | | |
| 2 Insurance fee and communication descending order of the | | ation. Enter the total fees and to | otal commissions paid. List in iter | m 3 the agents, brokers | s, and other persons in | | |
| (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | paid | | |
| | 2416 | | | | | | |
| 3 Persons receiving com | missions and f | ees. (Complete as many entrie | s as needed to report all persons |). | | | |
| <u> </u> | | | r, or other person to whom comm | | aid | | |
| FRANK CRYSTAL & CO | INC. | FL 1 | DLD SLIP 7 V YORK, NY 10005-3557 | | | | |
| (b) Amount of sales ar | nd hase | Fe | es and other commissions paid | | | | |
| commissions pai | | (c) Amount | (d) Purp | ose | (e) Organization code | | |
| | 2416 | 0 | | | 3 | | |
| | (a) Name a | and address of the agent, broke | r, or other person to whom comm | issions or fees were pa | aid | | |
| | | | | | | | |
| (b) Amount of sales ar | nd base | Fe | es and other commissions paid | | | | |
| commissions pai | d | (c) Amount | (d) Purp | ose | (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 indivithis report. | with each carrier may be | be treated as a unit for purposes of | | |
|---------|-------|--|--------------------------|--------------------------------------|------|---|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year e | | | 5 | 0 |
| _ | | racts With Allocated Funds: | | • | u | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
| | |

| P | If more than one contract covers the same ground information may be combined for reporting put the entire group of such individual contracts w | oup of employees of the surposes if such contracts a | are experienc | ce-rated as a unit. Whe | ere contracts | |
|----|--|--|---------------|-------------------------|---------------|------------------------|
| 8 | Benefit and contract type (check all applicable boxes) | | | | | |
| | a Health (other than dental or vision) | b Dental | С | Vision | (| d Life insurance |
| | e Temporary disability (accident and sickness) | f Long-term disabilit | у д [| Supplemental unemp | loyment I | h Prescription drug |
| | i Stop loss (large deductible) | j HMO contract | k [| PPO contract | • | I Indemnity contract |
| | | j | | 11 0 dominade | | I I Indemnity contract |
| | m ☐ Other (specify) ▶ | | | | | |
| 9 | Experience-rated contracts: | | | | | |
| | a Premiums: (1) Amount received | | 9a(1) | | 0 | |
| | (2) Increase (decrease) in amount due but unpaid | | 9a(2) | | 0 |] |
| | (3) Increase (decrease) in unearned premium rese | erve | 9a(3) | | 0 | |
| | (4) Earned ((1) + (2) - (3)) | | | | 9a(4) | 0 |
| | b Benefit charges (1) Claims paid | | 9b(1) | | 0 | |
| | (2) Increase (decrease) in claim reserves | | 9b(2) | | 0 | |
| | (3) Incurred claims (add (1) and (2)) | | | | 9b(3) | 0 |
| | (4) Claims charged | | | | 9b(4) | 0 |
| | c Remainder of premium: (1) Retention charges (on | n an accrual basis) | | | | |
| | (A) Commissions | | 9c(1)(A) | | 0 | |
| | (B) Administrative service or other fees | | 9c(1)(B) | | 0 |] |
| | (C) Other specific acquisition costs | | 9c(1)(C) | | 0 | |
| | (D) Other expenses | | 9c(1)(D) | | 0 |] |
| | (E) Taxes | | 9c(1)(E) | | 0 | |
| | (F) Charges for risks or other contingencies | | 9c(1)(F) | | 0 | |
| | (G) Other retention charges | | 9c(1)(G) | | 0 | |
| | (H) Total retention | | | | 9c(1)(H) | 0 |
| | (2) Dividends or retroactive rate refunds. (These | amounts were paid in | cash, or | credited.) | 9c(2) | 0 |
| | d Status of policyholder reserves at end of year: (1) | | | | 9d(1) | 0 |
| | (2) Claim reserves | · | | | 9d(2) | 0 |
| | (3) Other reserves | | | | 9d(3) | 0 |
| | e Dividends or retroactive rate refunds due. (Do no | | | | 9e | 0 |
| 10 | Nonexperience-rated contracts: | | . , , | | | |
| | Total premiums or subscription charges paid to ca | arrier | | | 10a | 24162 |
| | b If the carrier, service, or other organization incurre | ed any specific costs in co | onnection wit | h the acquisition or | 10b | 0 |
| | | ed any specific costs in co | onnection wit | h the acquisition or | 10a 10b | 241 |

| Part IV | Provision of Information | | | |
|------------------|---|-----|---|----|
| 11 Did th | e insurance company fail to provide any information necessary to complete 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

| nursuant to FDICA continue 402(a)(2) | | | | | n is Open to Public Inspection | | |
|--|------------------|--|---|--------------------|-----------------------------------|----------------|-----------------------|
| For calendar plan year 20 | 10 or fiscal pla | an year beginning 01/01/2010 | 0 | and end | ding 12 | /31/2010 | • |
| A Name of plan MOELIS & COMPANY H | OLDINGS HE | ALTH & WELFARE PLAN | | B Three- plan n | -digit number (PN | N) • | 501 |
| | | | | | | | |
| C Plan sponsor's name as shown on line 2a of Form 5500. MOELIS & COMPANY HOLDINGS D Employer Identification 20-8980370 | | | | ation Number (| EIN) | | |
| | | ning Insurance Contrac . Individual contracts grouped a | | | | | |
| 1 Coverage Information: | | | | | | | |
| (a) Name of insurance ca | | DMPANY | | | | D !! | |
| (b) EIN | (c) NAIC | (d) Contract or identification number | (e) Approximate nu persons covered a | | (6) | Policy or co | • |
| | code | identification number | policy or contrac | t year | (1) | From | (g) To |
| 47-0246511 | 71412 | GMTD0AEX4 | 25 | 51 | 01/01/20 | 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 t | he agents, | brokers, and c | ther persons in |
| (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | | | |
| | | 4540 | | | | | 0 |
| 3 Persons receiving com | | fees. (Complete as many entrie | | | | | |
| EDANIK ODVOTAL 8 CO | | and address of the agent, broke | er, or other person to who OLD SLIP | m commissio | ons or fees | were paid | |
| FRANK CRYSTAL & CO | INC. | FL | | , | | | |
| (b) Amount of sales a | nd hase | F | ees and other commission | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | | | (e) Organization code |
| | 4540 | 0 | | | | | 3 |
| | (a) Name | and address of the agent, broke | er or other person to who | m commissio | ons or fees | were paid | |
| | (u) Name | and address of the agent, broke | or, or other person to who | 11 0011111110010 | 0110 01 1000 | were paid | |
| | | | | | | | |
| (b) Amount of sales a | nd base | F | ees and other commission | ns paid | | | |
| commissions pa | id | (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 indivithis report. | with each carrier may be | be treated as a unit for purposes of | | |
|---------|-------|--|--------------------------|--------------------------------------|------|---|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year e | | | 5 | 0 |
| _ | | racts With Allocated Funds: | | • | u | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
| | |

| Pa | art II | Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts or | oup ourpose | es if such contracts | are experienc | ce-rated as a unit. Wh | ere contract | | |
|----|------------|--|-------------|-------------------------|---------------------|------------------------|--------------|--------------|-------------|
| 8 | Ben | efit and contract type (check all applicable boxes) | | 2011 0411101 11147 20 1 | | pa.poooo o. a | 7.000 | | |
| | a [| Health (other than dental or vision) | | Dental | сГ | Vision | | d Life insu | ırance |
| | L | | | | <u> </u> | <u></u> | | _ 📛 | |
| | e | Temporary disability (accident and sickness) | f ^ | J | · | = | pioyment | h ∐ Prescrip | • |
| | 1 [| Stop loss (large deductible) | l [| HMO contract | k_ | PPO contract | | I Indemn | ty contract |
| | m | Other (specify) | | | | | | | |
| 9 | Ехр | erience-rated contracts: | | | | | | | |
| | а | Premiums: (1) Amount received | | | 9a(1) | | 0 | _ | |
| | | (2) Increase (decrease) in amount due but unpaid | b | | | | 0 | _ | |
| | | (3) Increase (decrease) in unearned premium res | | • | | | 0 | | |
| | _ | (4) Earned ((1) + (2) - (3)) | | | | | . 9a(4) | | 0 |
| | b | Benefit charges (1) Claims paid | | | | | 0 | _ | |
| | | (2) Increase (decrease) in claim reserves | | | | | 1 | | |
| | | (3) Incurred claims (add (1) and (2)) | | | | | | | 0 |
| | | (4) Claims charged | | | | | . 9b(4) | | 0 |
| | С | Remainder of premium: (1) Retention charges (c | | | 0.(4)(4) | | 0 | 4 | |
| | | (A) Commissions | | | 9c(1)(A) | | 0 | 4 | |
| | | (B) Administrative service or other fees | | | | | 0 | 4 | |
| | | (C) Other specific acquisition costs | | | | | 0 | 4 | |
| | | (D) Other expenses | | | 9c(1)(D) | | 0 | 4 | |
| | | (E) Taxes | | | | | 0 | 4 | |
| | | (F) Charges for risks or other contingencies. | | | | | 0 | 4 | |
| | | (G) Other retention charges | | | | | | | 0 |
| | | (H) Total retention | | _ | | | · · · · · | | 0 |
| | | (2) Dividends or retroactive rate refunds. (These | | | <u> </u> | | | | 0 |
| | d | Status of policyholder reserves at end of year: (1 | • | • | | | | | 0 |
| | | (2) Claim reserves | | | | | | | 0 |
| | _ | (3) Other reserves | | | | | | 1 | 0 |
| 40 | | Dividends or retroactive rate refunds due. (Do n | ot incl | ude amount entered | d in c(2) .) | | . 9e | | 0 |
| IU | _ | nexperience-rated contracts: | | | | | 40- | | 54018 |
| | a | Total premiums or subscription charges paid to o | | | | | . 10a | | |
| | b | If the carrier, service, or other organization incurretention of the contract or policy, other than repr | | , , | | • | 10b | | 0 |
| | Sr | pecify nature of costs | ortou i | in an i, nom 2 abov | vo, roport am | | | 1 | |
| | ١ | rectify fluctuate of obstacle | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| Part IV | Provision of Information | | | |
|-----------|---|-----|------|--|
| 11 Did th | e insurance company fail to provide any information necessary to complete Schedule A? | Yes | X 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.

OMB No. 1210-0110

| Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | | | | This Fo | rm is Open to Public Inspection | |
|--|------------------|--|---|--------------------------|------------------------------------|--|
| For calendar plan year 20 | 10 or fiscal pla | n year beginning 01/01/2010 | and er | nding 12/31/2010 | | |
| A Name of plan MOELIS & COMPANY H | OLDINGS HEA | LTH & WELFARE PLAN | | e-digit number (PN) | 501 | |
| C Plan sponsor's name a MOELIS & COMPANY H | (EIN) | | | | | |
| on a separat | | ning Insurance Contract C Individual contracts grouped as a | | | | |
| 1 Coverage Information: | | | | | | |
| (a) Name of insurance ca | | MPANY | | | | |
| (b) EIN | (c) NAIC | (d) Contract or | (e) Approximate number of persons covered at end of | Policy or o | ontract year | |
| (b) EIN | code | identification number | policy or contract year | (f) From | (g) To | |
| 47-0246511 | 71412 | MP 0AEX4 | 244 | 01/01/2010 | 12/31/2010 | |
| 2 Insurance fee and com descending order of the | | ation. Enter the total fees and total | commissions paid. List in item 3 | the agents, brokers, and | other persons in | |
| (a) Total | amount of com | missions paid | (b) To | otal amount of fees paid | | |
| 836 0 | | | | | | |
| 3 Persons receiving com | missions and f | ees. (Complete as many entries a | as needed to report all persons). | | | |
| | | and address of the agent, broker, o | | ions or fees were paid | | |
| FRANK CRYSTAL & CO | | 32 OLI FL 17 | | | | |
| | | | · | | | |
| (b) Amount of sales a | nd base | Fees | and other commissions paid | | | |
| commissions pa | id | (c) Amount | (d) Purpose | (e) Organization code | | |
| | 836 | 0 | | | 3 | |
| | (a) Name a | and address of the agent, broker, o | or other person to whom commiss | ions or fees were paid | | |
| | (4) | | | | | |
| | | | | | | |
| (h) Amount of color | nd boos | Fees | and other commissions paid | | | |
| (b) Amount of sales an commissions pa | | (c) Amount | (d) Purpose | e | (e) Organization code | |
| · | | | | | | |
| | | | | | 1 | |

| 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 |
| | | | | |
| | | | | |

| Pá | art II | Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report. | ridual contracts | with each carrier may be | treated | d as a unit for purposes of |
|----|--------|--|-------------------|--------------------------|---------|-----------------------------|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year e | | | 5 | 0 |
| _ | | racts With Allocated Funds: | | • | u | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | _ | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
| | |

Part III

Part IV

Welfare Benefit Contract Information

| | | If more than one contract covers the same grainformation may be combined for reporting protection the entire group of such individual contracts of the entire group of the enti | urposes if such con | tracts are experienc | ce-rated as a unit. Whe | ere contracts | |
|----|-----|--|-----------------------|---------------------------|-------------------------|---------------|----------------------|
| 8 | Ben | efit and contract type (check all applicable boxes) | | | | | |
| | а | Health (other than dental or vision) | b Dental | с | Vision | | d Life insurance |
| | е | Temporary disability (accident and sickness) | f Long-term | disability g | Supplemental unemp | lovment | h Prescription drug |
| | i | Stop loss (large deductible) | j HMO contra | , <u> </u> | PPO contract | , | I Indemnity contract |
| | m [| | J [] TIMO COITE | K L | 11 O contract | | I Indemnity contract |
| | [| Other (specify) | | | | | |
| 9 | Exp | erience-rated contracts: | | | | | |
| Ŭ | | Premiums: (1) Amount received | | 9a(1) | | 0 | 4 |
| | | (2) Increase (decrease) in amount due but unpaid | | | | 0 | = |
| | | (3) Increase (decrease) in unearned premium res | | | | 0 | |
| | | (4) Earned ((1) + (2) - (3)) | | | | 9a(4) | 0 |
| | b | Benefit charges (1) Claims paid | | 9b(1) | | 0 | |
| | | (2) Increase (decrease) in claim reserves | | 9b(2) | | 0 | |
| | | (3) Incurred claims (add (1) and (2)) | | | | 9b(3) | 0 |
| | | (4) Claims charged | | | | 9b(4) | 0 |
| | С | Remainder of premium: (1) Retention charges (o | n an accrual basis |) | | | |
| | | (A) Commissions | | 9c(1)(A) | | 0 | |
| | | (B) Administrative service or other fees | | 9c(1)(B) | | 0 | |
| | | (C) Other specific acquisition costs | | 9c(1)(C) | | 0 | |
| | | (D) Other expenses | | 9c(1)(D) | | 0 | |
| | | (E) Taxes | | 9c(1)(E) | | 0 | |
| | | (F) Charges for risks or other contingencies. | | | | 0 | |
| | | (G) Other retention charges | | 9c(1)(G) | | 0 | |
| | | (H) Total retention | | | | 9c(1)(H) | 0 |
| | | (2) Dividends or retroactive rate refunds. (These | amounts were | paid in cash, or | credited.) | 9c(2) | 0 |
| | d | Status of policyholder reserves at end of year: (1 |) Amount held to p | rovide benefits after | retirement | 9d(1) | 0 |
| | | (2) Claim reserves | | | | 9d(2) | 0 |
| | | (3) Other reserves | | | | 9d(3) | 0 |
| | е | Dividends or retroactive rate refunds due. (Do n | ot include amount | entered in c(2) .) | | 9e | 0 |
| 10 | No | nexperience-rated contracts: | | | | | |
| | а | Total premiums or subscription charges paid to o | arrier | | | 10a | 8359 |
| | b | If the carrier, service, or other organization incurr | red any specific cos | sts in connection wit | h the acquisition or | | 0 |
| | | retention of the contract or policy, other than rep | orted in Part I, item | 2 above, report am | ount | 10b | 0 |
| | Sp | pecify nature of costs | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

X No

Yes

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

Provision of Information

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 Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This F | | | | n is Open to Public Inspection | | | |
|--|------------------|--|--------------------------------------|-----------------------------------|-----------------------|------------------|-----------------------|
| For calendar plan year 20° | 10 or fiscal pla | an year beginning 01/01/2010 |) | and er | nding 12 | /31/2010 | |
| A Name of plan MOELIS & COMPANY HO | OLDINGS HE | ALTH & WELFARE PLAN | | B Three plan | e-digit number (Pl | N) • | 501 |
| | | | | | | | |
| C Plan sponsor's name a MOELIS & COMPANY HO | | ne 2a of Form 5500. | | D Emplo 20-898 | - | cation Number (| EIN) |
| | | ning Insurance Contrac Individual contracts grouped a | | | | | |
| 1 Coverage Information: | | | | | | | |
| (a) Name of insurance can MUTUAL OF OMAHA INS | | DMPANY | | | | | |
| | (c) NAIC | (d) Contract or | (e) Approximate no | | | Policy or co | entract year |
| (b) EIN | code | identification number | persons covered a policy or contract | | (f) | From | (g) To |
| 47-0246511 | 71412 | GMSA0AEX4 | | 57 | 01/01/20 |)10 | 12/31/2010 |
| 2 Insurance fee and communication descending order of the | | nation. Enter the total fees and t | otal commissions paid. L | ist in item 3 | the agents | , brokers, and o | ther persons in |
| (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | | | |
| 3 Parsons receiving com | missions and | fees. (Complete as many entric | as as needed to report all | nercone) | | | 0 |
| J 1 ersons receiving com | | | | | iono or food | wore poid | |
| FRANK CRYSTAL & CO | | FL. | OLD SLIP | | ions or rees | s were paid | |
| | | | ees and other commission | ne naid | | | |
| (b) Amount of sales an commissions pai | | (c) Amount | | (d) Purpose | | | (e) Organization code |
| | 446 | 0 | | | | | 3 |
| | (a) Name | and address of the agent, broke | er, or other person to who | m commiss | ions or fees | were paid | |
| | | | | | | | |
| (b) Amount of sales and base | | | ees and other commission | | | | (e) Organization code |
| commissions pai | u | (c) Amount | | (d) Purpose | 5 | | (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 |
| | | | | |
| | | | | |

| Pá | art II | Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report. | ridual contracts | with each carrier may be | treated | d as a unit for purposes of |
|----|--------|--|-------------------|--------------------------|---------|-----------------------------|
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year e | | | 5 | 0 |
| _ | | racts With Allocated Funds: | | • | u | |
| | а | State the basis of premium rates • | | | | |
| | b | Premiums paid to carrier | | | 6b | 0 |
| | С | Premiums due but unpaid at the end of the year | | | 6c | 0 |
| | d | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 0 |
| | | Specify nature of costs | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred (3) other (specify) | d annuity | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | nating plan ched | ck here | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | intained in sepa | arate accounts) | | |
| | а | Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶ | ate participation | guarantee | | |
| | b | Balance at the end of the previous year | | | 7b | 0 |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) | | 0 | |
| | | (2) Dividends and credits | . 7c(2) | | 0 | |
| | | (3) Interest credited during the year | 7c(3) | | 0 | |
| | | (4) Transferred from separate account | . 7c(4) | | 0 | |
| | | (5) Other (specify below) | 7c(5) | | 0 | |
| | | • | | | | |
| | | (6)Total additions | | | c(6) | 0 |
| | ď | Total of balance and additions (add b and c(6)) | | | 7d | 0 |
| | | Deductions: | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | | | 0 | |
| | | (2) Administration charge made by carrier | 7e(2) | | 0 | |
| | | (3) Transferred to separate account | | | 0 | |
| | | (4) Other (specify below) | . 7e(4) | | 0 | |
| | | > | | | | |
| | | (5) Total deductions | | 76 | e(5) | 0 |
| | f | Balance at the end of the current year (subtract e(5) from d) | | | 7f | 0 |

| Page | 4 |
|------|---|
|------|---|

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.

Part III

Welfare Benefit Contract Information

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

| 8 1 | senetit a | and contract type (check all applicable boxes) | | | | _ | _ | | | |
|-----|-----------|--|--------|--------------|-------------------------|----------|-------------------|-----------------|-----------------|-------------|
| ć | а 🗌 н | ealth (other than dental or vision) | b | Dental | | С | Vision | | d Life insu | urance |
| • | • 🗌 T | emporary disability (accident and sickness) | f | Long-term di | isability | g | Supplemental unem | ployment | h Prescrip | otion drug |
| i | ∏ s | top loss (large deductible) | jΓ | HMO contrac | ct | k | PPO contract | | I Indemni | ty contract |
| r | | ther (specify) ► AD&D | | 1 | | <u></u> | | | Ш | • |
| • | ⊔ ັ | ther (opeony) | | | | | | | | |
| 9 F | xperien | nce-rated contracts: | | | | | | | | |
| | | niums: (1) Amount received | | | 9a(| 1) | | 0 | | |
| | | Increase (decrease) in amount due but unpaid | | | | | | 0 | | |
| | | Increase (decrease) in unearned premium rese | | | | - | | 0 | | |
| | . , | Earned ((1) + (2) - (3)) | | | | _ | I. | 9a(4) | | 0 |
| | . ` ′ | nefit charges (1) Claims paid | | | | | | 0 | | |
| | | Increase (decrease) in claim reserves | | | | - | | 0 | | |
| | . , | Incurred claims (add (1) and (2)) | | | | | <u> </u> | 9b(3) | | 0 |
| | | Claims charged | | | | | | 9b(4) | | 0 |
| | ` ' | mainder of premium: (1) Retention charges (or | | | | | | | | |
| | | (A) Commissions | | | | (A) | | 0 | | |
| | | (B) Administrative service or other fees | | | - 441 | | | 0 | | |
| | | (C) Other specific acquisition costs | | | 2 (4) | | | 0 | 1 | |
| | | (D) Other expenses | | | | | | 0 | | |
| | | (E) Taxes | | | <u> </u> | <u> </u> | | 0 | 1 | |
| | | (F) Charges for risks or other contingencies | | | | | | 0 | 1 | |
| | | (G) Other retention charges | | | 2 (4) | | | 0 | | |
| | | (H) Total retention | | | | | I | 9c(1)(H) | | 0 |
| | (2) | Dividends or retroactive rate refunds. (These | | _ | | | | | | 0 |
| | | atus of policyholder reserves at end of year: (1) | | _ | | _ | | | | 0 |
| | | Claim reserves | | • | | | | 9d(2) | | 0 |
| | ` ' | Other reserves | | | | | | 9d(3) | | 0 |
| | ` ' | ridends or retroactive rate refunds due. (Do no | | | | | | | | 0 |
| | | perience-rated contracts: | 11101 | ado amount o | increa iii o(2) | ., | | ₁ JC | | |
| | | tal premiums or subscription charges paid to ca | arrier | | | | | 10a | | 4463 |
| | _ | ne carrier, service, or other organization incurre | | | | | | 100 | | |
| | | ention of the contract or policy, other than repo | | , , | | | • | . 10b | | 0 |
| | Specif | y nature of costs | | | | | | | | _ |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| D: | 4 11 / | Duaviaian of Information | | | | | | | | |
| Par | | Provision of Information | | | | | | | <u>▼</u> | |
| 11 | Did the | insurance company fail to provide any informa | ation | necessary to | complete Sch | nedule | e A? | Yes | ^X No | |

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

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 01/01/2010 | and ending 12/31/2010 | J |
|--|---|--|
| A Name of plan MOELIS & COMPANY HOLDINGS HEALTH & WELFARE PLAN | B Three-digit | 501 |
| WOELIS & COMPANT HOLDINGS HEALTH & WELFARE PLAN | plan number (PN) | • |
| | | |
| C Plan sponsor's name as shown on line 2a of Form 5500 | D Employer Identification No | umber (EIN) |
| MOELIS & COMPANY HOLDINGS | 20-8980370 | , |
| | | |
| Don't I Comica Draviday Information (see instructions) | | |
| 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 complan during the plan year. If a person received only eligible indirect compensation answer line 1 but are not required to include that person when completing the remains | onnection with services rendered to the p for which the plan received the required | plan or the person's position with the |
| 1 Information on Persons Receiving Only Eligible Indirect Comp | pensation | |
| a Check "Yes" or "No" to indicate whether you are excluding a person from the remain | | only eligible |
| indirect compensation for which the plan received the required disclosures (see inst | tructions for definitions and conditions) | Yes 🔀 No |
| b If you answered line 1a "Yes," enter the name and EIN or address of each person | providing the required disclosures for the | e service providers who |
| received only eligible indirect compensation. Complete as many entries as needed | | • |
| (b) Enter name and EIN or address of person who provide | d you disclosures on eligible indirect con | npensation |
| | | |
| | | |
| | | |
| (b) Enter name and EIN or address of person who provide | d you disclosure on eligible indirect com | pensation |
| | | |
| | | |
| | | |
| | | |
| (b) Enter name and EIN or address of person who provided | d you disclosures on eligible indirect com | pensation |
| | | · |
| | | |
| | | |
| | | |
| (b) Enter name and EIN or address of person who provided | d vou disclosures on cligible indirect com | nensation |
| (b) Enter frame and Envior address of person who provided | a you disclosules on eligible indirect con | iperisation |

| | 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 |
| | | | |
| | | | |

| answered | f "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) | | |
| ADP | | | 504 CLIN' STE 4400 | TON DR | | |
| (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? |
| 12 13 | NONE | 4364 | Yes No X | Yes No 🖺 | 0 | 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) | 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 550 | 0) 2010 | | Page 4- | | |
|--|--|---|---|---|--|---|
| | | | | | | |
| | | (| 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 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 | (d) 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 | (g) 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 ea this Schedule. | 3 · · · · · · · · · · · · · · · · · · · | | | | |
| (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 | |
|------|-----|--|
| | | |

| Pa | art III | Termination Information on Accountants and Enrolled A (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 LIN. |
| d | Addres | | e Telephone: |
| - | 7.00.00 | - | Total state of the |
| | | | |
| Ex | planatior | | |
| _^ | , | | |
| | | | |
| | | | |
| а | Name: | | b EIN: |
| С | Positio | n: | |
| d | Addres | | e Telephone: |
| | | | · |
| | | | |
| | | | |
| Ex | planatior | : | |
| | | | |
| | | | |
| | | | |
| а | Name: | | b EIN; |
| С | Positio | n: | |
| d | Addres | s: | e Telephone: |
| | | | |
| | | | |
| | | | |
| Ex | planatior | : | |
| | | | |
| | | | |
| | | | 1. |
| <u>a</u> | Name: | | b EIN; |
| <u>c</u> | Positio | | |
| d | Addres | S: | e Telephone: |
| | | | |
| | | | |
| | nlonatic: | | |
| ΕX | planatior | | |
| | | | |
| | | | |