E	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110
Form 5500	This form is required to be filed for employee benefit plans under sections 104	1210-0089
Department of the Treasury Internal Revenue Service	and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).	2011
Department of Labor Employee Benefits Security Administration	 Complete all entries in accordance with the instructions to the Form 5500. 	
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection
Part I Annual Report Ider	ntification Information	
For calendar plan year 2011 or fiscal	plan year beginning 05/01/2011 and ending 04/30/	2012
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or	
	a single-employer plan; a DFE (specify)	
B This return/report is:	the first return/report; the final return/report;	
	an amended return/report; a short plan year return/report (less t	han 12 months).
C If the plan is a collectively-bargain	ed plan, check here	
D Check box if filing under:	Form 5558; automatic extension;	the DFVC program;
	special extension (enter description)	_
Part II Basic Plan Inform	nation—enter all requested information	
1a Name of plan HORIZON REALTY ADVISORS, LLC		1b Three-digit plan number (PN) ►
·		1c Effective date of plan 05/01/2011
2a Plan sponsor's name and addres	s, including room or suite number (Employer, if for single-employer plan)	2b Employer Identification Number (EIN)
HORIZON REALTY ADVISORS, LLC		91-2092900
ERICA MURRY, BUSINESS MANAG	ER	2c Sponsor's telephone number 206-260-1505
2800 ELLIOTT AVE., STE A SEATTLE, WA 98121	2800 ELLIOTT AVE., STE A SEATTLE, WA 98121	2d Business code (see instructions) 531310

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	11/19/2012	ERICA MURRAY
TIERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
NEKE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2011) v.012611

	Plan administrator's name and address (if same as plan sponsor, enter "Same")		dministrator's EIN
	DRIZON REALTY ADVISORS, LLC RICA MURRY, BUSINESS MANAGER	-	-2092900
28	00 ELLIOTT AVE., STE A		dministrator's telephone umber
56	ATTLE, WA 98121		206-260-1505
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:	l and	4b EIN
а	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year	5	166
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
-		. 6a	152
а	Active participants	. 0a	132
b	Retired or separated participants receiving benefits	. 6b	
~	Other retired or concreted participants antitled to future hanefits	6c	
C	Other retired or separated participants entitled to future benefits		
d	Subtotal. Add lines 6a, 6b, and 6c	. 6d	152
۵	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
C	Deceased participants whose beneficianes are receiving of are entitled to receive benefits		
f	Total. Add lines 6d and 6e	. 6f	152
a	Number of participants with account balances as of the end of the plan year (only defined contribution plans		
g	complete this item)	. 6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		
82	If the plan provides pansion handlits, optar the applicable pansion feature codes from the List of Plan Characteristic Code	-	inotructiono.

Form 5500 (2011)

Page 2

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

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

9a	9a Plan funding arrangement (check all that apply)			9b	Plan be	lan benefit arrangement (check all that apply)			
	(1)	X	Insurance		(1)	X	h	nsurance	
	(2)		Code section 412(e)(3) insurance contracts		(2)		C	Code section 412(e)(3) insurance contracts	
	(3)		Trust		(3)		Т	rust	
	(4)	X	General assets of the sponsor		(4)	X	Ċ	Seneral assets of the sponsor	
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)								
a Pension Schedules			b General Schedules				lules		
	(1)		R (Retirement Plan Information)		(1)			H (Financial Information)	
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)			I (Financial Information – Small Plan)	
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X		A (Insurance Information)	
			actuary		(4)	X		C (Service Provider Information)	
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (DFE/Participating Plan Information)	
	.,		Information) - signed by the plan actuary		(6)			G (Financial Transaction Schedules)	

SCHEDULE A Insurance Information			n		OM	B No. 1210-0110		
(Form 5500 Department of the Treas	,	This schedule is required	to be filed under section	on 104 of th	e			
Internal Revenue Serv	ice	Employee Retirement Inc		of 1974 (ERISA).			2011	
Employee Benefits Security Ad	ministration	File as an a	ttachment to Form 55	00.				
Pension Benefit Guaranty Co	rporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		lion		m is Open to Public Inspection	
For calendar plan year 20	11 or fiscal plar	year beginning 05/01/2011		and ending 04/30/2012				
A Name of plan HORIZON REALTY ADVI	SORS, LLC				e-digit number (P	N) 🕨	797	
C Plan sponsor's name as shown on line 2a of Form 5500 HORIZON REALTY ADVISORS, LLC				D Emplo 91-209	•	cation Number ((EIN)	
		ing Insurance Contract (Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca CIGNA HEALTH AND LIF		E COMPANY						
	(c) NAIC	(d) Contract or (e) Approximate no		umber of		Policy or co	ontract year	
(b) EIN (c) NAIC code		identification number persons covered policy or contra		(†)		From	(g) To	
59-1031071	67369	606059	152 05/		05/01/20)11	04/30/2012	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in	
(a) Total a	amount of comr	missions paid		(b) To	otal amount	of fees paid		
		24387						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker,		m commiss	ions or fees	s were paid		
DANIEL D NELSON			EAST BUTEO DR. TSDALE, AZ 85255					
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code	
24387								
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid		
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid				
commissions paid (c) Amount				(d) Purpos	e	(e) Organization code		

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

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

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

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

 (c) Amount
 (d) Purpose
 code

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

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

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

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

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

Page 3

P	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	A	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	- 4-3			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

Page 4

	he same employer(s) or members of the same employee organizations(s), the cts are experience-rated as a unit. Where contracts cover individual employees, be treated as a unit for purposes of this report.
8 Benefit and contract type (check all applicable boxes)	
a 🛛 Health (other than dental or vision) b 🕅 Dental	c Vision d X Life insurance
e Temporary disability (accident and sickness) f T Long-term disa	$\mathbf{g} \square$ Supplemental unemployment $\mathbf{h} \square$ Prescription drug
i Stop loss (large deductible) j HMO contract	
m ☐ Other (specify) ►	
9 Experience-rated contracts:	
a Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	
(E) Taxes	
(F) Charges for risks or other contingencies	
(G) Other retention charges	
(H) Total retention	
(2) Dividends or retroactive rate refunds. (These amounts were pair	d in cash, or credited.)
d Status of policyholder reserves at end of year: (1) Amount held to provi	ide benefits after retirement
(2) Claim reserves	
(3) Other reserves	
e Dividends or retroactive rate refunds due. (Do not include amount enter	ered in c(2) .)
10 Nonexperience-rated contracts:	
a Total premiums or subscription charges paid to carrier	
b If the carrier, service, or other organization incurred any specific costs i retention of the contract or policy, other than reported in Part I, item 2 a	

Specify nature of costs

Part IV Provision of Information

11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	>	× No	
12	If the answer to line 11 is "Yes," specify the information not provided.				

91-209290 Part I Information Concerning Insurance Contract Coverage, Fees, and Commission on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported 1 Coverage Information: (a) Name of insurance carrier THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (b) EIN (c) NAIC (c) NAIC (d) Contract or identification number 13-5123390 64246 00466797 (c) Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the descending order of the amount paid.	04/30/2012 t ber (PN) lentification Numb sions Provide inf on a single Sched	formation for each contract
Employee Benefits Security Administration Pension Benefit Guarany Corporation Pension Benefit Guarany Corporation Pension Benefit Guarany Corporation For calendar plan year 2011 or fiscal plan year beginning 05/01/2011 A Name of plan HORIZON REALTY ADVISORS, LLC C Plan sponsor's name as shown on line 2a of Form 5500 Part I Information Concerning Insurance Contract Coverage, Fees, and Commis on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported 1 Coverage Information: (a) Name of insurance carrier THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year 13-5123390 64246 00466797 152 (d) 12206 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the descending order of the amount paid. (a) Total amount of commissions paid (b) Total (a) Name and address of the agent, broker, or other person to whom commissions paid 9668 EAST BUTEO DR SCOTTSDALE, AZ 85255	04/30/2012 t ber (PN) lentification Numb sions Provide inf on a single Sched	Form is Open to Public Inspection 797 Der (EIN) formation for each contract tule A.
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). For calendar plan year 2011 of fiscal plan year beginning 05/01/2011 and endine A Name of plan HORIZON REALTY ADVISORS, LLC C Plan sponsor's name as shown on line 2a of Form 5500 HORIZON REALTY ADVISORS, LLC Part I Information Concerning Insurance Contract Coverage, Fees, and Commission a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported to report all momentation. (a) Name of insurance carrier THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (b) EIN (c) NAIC (c) NAIC (c) (d) Contract or identification number of policy or contract year 13-5123390 64246 00466797 152 (c) 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the descending order of the amount paid. (a) Total amount of commissions paid (b) Total 12206 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 commission: DANIEL D NELSON (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (c) Amount of sales and base (c) Amount (d) Purpose (d) Amount of sales and base (c) Amount (d) Purpose (d) Purpose (e) Amount of sales and base (c) Amount (d) Purpose (d) Purpose (d) Purpose (d) Purpose (d) Purpose (e) Amount of sales and base (c) Amount (d) Purpose 	04/30/2012 t ber (PN) lentification Numb sions Provide inf on a single Sched	Inspection 797 Der (EIN) formation for each contract tule A.
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DANIEL D NELSON 9668 EAST BUTEO DR SCOTTSDALE, AZ 85255 (b) Amount of sales and base commissions paid Fees and other commissions paid (c) Amount (d) Purpose	or fees were naid	
(b) Amount of sales and base commissions paid Fees and other commissions paid (c) Amount (d) Purpose		
commissions paid (c) Amount (d) Purpose		
commissions paid (c) Amount (d) Purpose		
		(e) Organization code
(a) Name and address of the agent, broker, or other person to whom commission	r fees were paid	
DANIEL NELSON FINANCIAL GROUP 9668 EAST BUTEO DR SCOTTSDALE, AZ 85255		
SCOTTOBALL, AZ 05255		
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose	•	
3752 FEES		(e) Organization code

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

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

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

 (c) Amount
 (d) Purpose
 code

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

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

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

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

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

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P	art I							
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end					
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5			
6	Con	tracts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier			6b			
	С	Premiums due but unpaid at the end of the year			6c			
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferre	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma						
	а		ate participatio	• /				
		(3) guaranteed investment (4) other	•					
	b	Balance at the end of the previous year			7b			
	С	Additions: (1) Contributions deposited during the year						
		(2) Dividends and credits						
		(3) Interest credited during the year						
		(4) Transferred from separate account						
		(5) Other (specify below)	7c(5)					
		•						
					70(0)			
	A	(6)Total additions			7c(6) 7d			
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u			
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier						
		(3) Transferred to separate account	_ (-)					
		(4) Other (specify below)						
		·						
		(5) Total deductions			7e(5)			
	f	Balance at the end of the current year (subtract e(5) from d)						

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Part III Welfare Benefit Contract Information If more than one contract covers the same group information may be combined for reporting purpor the entire group of such individual contracts with individual contracts with	of employees of the sa ses if such contracts a	re experienc	ce-rated as a unit. Whe	ere contract	
8 Benefit and contract type (check all applicable boxes)					
a Health (other than dental or vision) b	X Dental	с	Vision		d X Life insurance
e Temporary disability (accident and sickness) f	Long-term disability	g	Supplemental unemp	olovment	h X Prescription drug
i Stop loss (large deductible)	HMO contract	k [PPO contract	,	I Indemnity contract
		n _			
m _ Other (specify) ►					
9 Experience-rated contracts:					
a Premiums: (1) Amount received	Г	9a(1)			-
(2) Increase (decrease) in amount due but unpaid		9a(2)			1
(3) Increase (decrease) in unearned premium reserve		9a(3)			1
(4) Earned ((1) + (2) - (3))				9a(4)	
b Benefit charges (1) Claims paid					
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))				9b(3)	
(4) Claims charged				9b(4)	
C Remainder of premium: (1) Retention charges (on an	n accrual basis)				_
(A) Commissions		9c(1)(A)			_
(B) Administrative service or other fees		9c(1)(B)			_
(C) Other specific acquisition costs		9c(1)(C)			4
(D) Other expenses		9c(1)(D)			4
(E) Taxes		9c(1)(E)			4
(F) Charges for risks or other contingencies		9c(1)(F)			4
(G) Other retention charges		9c(1)(G)		0.(4)(1))	
(H) Total retention	—			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These am				9c(2)	4
d Status of policyholder reserves at end of year: (1) Ar	•			9d(1)	4
(2) Claim reserves				9d(2)	
(3) Other reserves				9d(3)	
Dividends or retroactive rate refunds due. (Do not in	iclude amount entered	ın c(2) .)		9e	
10 Nonexperience-rated contracts:				40-	
a Total premiums or subscription charges paid to carrie				10a	115858
b If the carrier, service, or other organization incurred a retention of the contract or policy, other than reported				10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE C	Service Provider	Information	OMB No. 1210-0110		
(Form 5500)			2011		
Department of the Treasury Internal Revenue Service	This schedule is required to be filed und Retirement Income Security A			2011	
Department of Labor Employee Benefits Security Administration	File as an attachmen	This	Form is Open to Public Inspection.		
Pension Benefit Guaranty Corporation For calendar plan year 2011 or fiscal pla	an year beginning 05/01/2011	and ending 04/30	0/2012	inspection	
A Name of plan		B Three-digit			
HORIZON REALTY ADVISORS, LLC		plan number (PN)	•	797	
C Plan sponsor's name as shown on lin	ne 2a of Form 5500	D Employer Identificat	ion Number	(EIN)	
HORIZON REALTY ADVISORS, LLC		91-2092900			
Part I Service Provider Info	ormation (see instructions)				
or more in total compensation (i.e., m plan during the plan year. If a persor answer line 1 but are not required to 1 Information on Persons Re a Check "Yes" or "No" to indicate wheth indirect compensation for which the p b If you answered line 1a "Yes," enter received only eligible indirect comper	rdance with the instructions, to report the info noney or anything else of monetary value) in on a received only eligible indirect compensation include that person when completing the rem ceiving Only Eligible Indirect Com her you are excluding a person from the rema- blan received the required disclosures (see inse- the name and EIN or address of each person insation. Complete as many entries as needed me and EIN or address of person who provid	connection with services rendered to n for which the plan received the required of this Part. Appensation ainder of this Part because they rece structions for definitions and condition n providing the required disclosures d (see instructions).	b the plan or uired disclosed eived only el ons)	the person's position with the sures, you are required to	
(b) Enter na	ame and EIN or address of person who provid	ded vou disclosure on eliaible indirec	t compensa	ation	
(b) Enter na	me and EIN or address of person who provide	ed you disclosures on eligible indire	ct compens	ation	

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

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

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

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

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

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

(a) Enter name and EIN or address (see instructions)

CIGNA HEALTH AND LIFE INURANCE CO

59-1031071

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a
	organization, or	by the plan. If none,		compensation, for which the	service provider excluding	formula instead of
	person known to be	enter -0	other than plan or plan	plan received the required	eligible indirect	an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you	estimated amount?
					answered "Yes" to element	
					(f). If none, enter -0	
23 53	NONE	3836			0	
			Yes No X	Yes 🗌 No 🗙		Yes No
					1	<u> </u>
		(a) Enter name and EIN or	address (see instructions)		

THE GUARDIAN LIFE INS CO

13-5123390

(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service Code(s)	person known to be a party-in-interest		Did service provider	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	Did the service provider give you a formula instead of an amount or		
23 53	NONE	0	Yes 🗌 No 🗙	Yes 🗌 No 🔀	0	Yes 🗌 No 🗙		
	(a) Enter name and EIN or address (see instructions)							
		(

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(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?	service provider excluding eligible indirect compensation for which you	
		Yes No	Yes No	answered "Yes" to element (f). If none, enter -0	Yes No

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

(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			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 person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			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 person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗌

Part I Service Provider Information (continued)

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

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

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Ρ	art II Serv	vice Providers Who Fail or Refuse to	Provide Infor	mation			
4	4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.						
	(a) Enter nam	e 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 nam	e 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 nam	e 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 nam	e and EIN or address of service provider (see instructions)	(b) Nature of Service	(C) Describe the information that the service provider failed or refused to provide			
	(a) Enter nam	e and EIN or address of service provider (see	(b) Nature of	(C) Describe the information that the service provider failed or refused to			
		instructions)	Service Code(s)	provide			
	(a) Enter nam	e 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			

Part III		Termination Information on Accountants and Enrolled Actuaries (see in (complete as many entries as needed)	nstructions)
а	Name		b EIN:
C Position:		n:	
d	Addres	SS:	e Telephone:
Ex	planatio	n:	

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation: