Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), 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

2012

This Form is Open to Public Inspection

						Inspection	
Part I	Annual Report Identific	cation Information					
For caler	ndar plan year 2012 or fiscal plan	year beginning 01/01/2008		and ending 12/3	31/2008		
A This	eturn/report is for:	a multiemployer plan;	a multipl	e-employer plan; or			
		x a single-employer plan;	a DFE (s	specify)			
_		The first return (see eat.					
B This r	eturn/report is:	the first return/report;	=	return/report;		4	
0		an amended return/report;	_	olan year return/report (les		onths).	
	, , , , ,	olan, check here)	
D Chec	k box if filing under:	☐ Form 5558;		c extension;	X th	e DFVC program;	
		special extension (enter desc					
Part		ion—enter all requested informat	tion				Т
	e of plan BERTS CONTRACTING, INC FL	LEXIBLE BENEFITS PLAN			1b	Three-digit plan number (PN) ▶	501
	,				1c	Effective date of pl	an
		clude room or suite number (empl	loyer, if for a single	-employer plan)	2b	Employer Identifica Number (EIN) 59-1683951	ation
C.W. RC	BERTS CONTRACTING, INC				20	Sponsor's telephor	20
					number 850-385-5060		
PO BOX HOSFOR	188 RD, FL 32334	PO BOX 18 HOSFORD	88), FL 32334		2d	Business code (seinstructions)	е
						237310	
Caution	A penalty for the late or incom	nplete filing of this return/report	t will be assessed	unless reasonable caus	se is establis	shed.	
		alties set forth in the instructions, I ne electronic version of this return					
SIGN HERE	Filed with authorized/valid electron	onic signature.	08/27/2013	ALAN PALMER			
HEKE	Signature of plan administrate	or	Date	Enter name of individua	al signing as	plan administrator	
SIGN							
HERE	Signature of employer/plan sp	noncor	Date	Enter name of individua	al cigning ac	omployer or plan en	oncor
	Signature of employer/plan Sp	polisor	Date	Enter name or marvious	ai signing as	employer or plan sp	OHSOI
SIGN							
HERE	Signature of DFE		Date	Enter name of individua	al cianina ac	DEE	
Preparer	<u> </u>	applicable) and address; include ro				telephone number	
			(optional)				
MCDANIEL & ASSOCIATES, P. C.					334-792-2153		
P. O. BC DOTHAN	X 6356 I, AL 36302-6356						

Form 5500 (2012) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor Name	Same as Plan Sponsor Address	3b Administrator's EIN
			3c Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed for this plan, enter the name,	4b EIN
а	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year		5 316
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6b, 6c, and 6d).	
а	Active participants		. 6a 456
b	Retired or separated participants receiving benefits		. 6b
С	Other retired or separated participants entitled to future benefits		. 6c
d	Subtotal. Add lines 6a, 6b, and 6c		. 6d 456
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	. 6e
f	Total. Add lines 6d and 6e		. 6f
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h
7	Enter the total number of employers obligated to contribute to the plan (only	. 7	
	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits.		
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that	at apply)
	(1) X Insurance	(1) X Insurance	
	Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance contracts
	(3) Trust (4) General assets of the sponsor	(3) Trust (4) X General assets of the specific control	ooneor
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a		
			or anadirous (Goo mondono)
а	Pension Schedules (1) R (Retirement Plan Information)	b General Schedules	
		(1) H (Financial Inforr	mation)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Inform	nation – Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X 3 A (Insurance Infor	•
	· —	(4) C (Service Provide	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		ing Plan Information)
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction Schedules)

SCHEDULE A (Form 5500)

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

2012

Pension Benefit Guaranty Co	rporation		s are required to provide to DERISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20°	12 or fiscal pla	n year beginning 01/01/200	8	and en	ding 12	/31/2008	•
A Name of plan C.W. ROBERTS CONTRA	ACTING, INC I	FLEXIBLE BENEFITS PLAN			e-digit number (PI	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 C.W. ROBERTS CONTRACTING, INC				D Emplo 59-168	-	ation Number	(EIN)
Part I Information on a separate	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 can	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
47-0098400	61301	010-030063	23	32	01/01/20	08	12/31/2008
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		5695		. ,			0
3 Persons receiving com	missions and	ees. (Complete as many entrie	es as needed to report all	nercone)			
J Fersons receiving com		and address of the agent, broke			ions or fees	were naid	
BB&T INSURANCE SER		337	75-B CAPITAL CIRCLE LLAHASSEE, FL 32308	m commissi	10113 01 1003	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpose	9		(e) Organization code
	5695						3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(a) Hame and dadress of the agent, sector, or other person to when commissions or loss have para							
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			_
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code

Schedule A (Form 5500)	2012	Page 2 - 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	,	.,,	
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
()) !			• • • • • • • • • • • • • • • • • • • •
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	T		<u> </u>
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	, , , , , , , , , , , , , , , , , , ,		
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
•	, ,		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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ay		•

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purpose						as a unit for purposes of
_		this report.				
		nt value of plan's interest under this contract in the general account at year				
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5	
ь		acts With Allocated Funds:				
	а	State the basis of premium rates				
	L	December 2 and the country			Ch	
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
	;	Specify nature of costs				
	e	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan d	heck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
•				ion guarantee		
	u			.o guarantos		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)					
		(C) Total additions			7c(6)	0
	_	(6)Total additions			76(6)	
		otal of balance and additions (add lines 7b and 7c(6))	Γ		/u	
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		Administration charge made by carrier	7e(1)			
		3) Transferred to separate account	7e(2)			
	`	4) Other (specify below)	7e(3)			
	(T) Outor (specify below)	, 5(7)			
	ļ	•				
	(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2012		Page 4		
If more than one contract covers the same ginformation may be combined for reporting the entire group of such individual contracts	group of employees of the sar ourposes if such contracts are	e experience-rated as a	unit. Where contract	
Benefit and contract type (check all applicable boxes	.)			
a Health (other than dental or vision)	b X Dental	C Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	g Supplemen	ntal unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k PPO contr		I Indemnity contract
m ☐ Other (specify) ▶	,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
The Strict (Specify)				
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		7
(2) Increase (decrease) in amount due but unpa	id	9a(2)		
(3) Increase (decrease) in unearned premium re	serve	9a(3)		
(4) Earned ((1) + (2) - (3))	<u></u>		9a(4)	
b Benefit charges (1) Claims paid		9b(1)		
(2) Increase (decrease) in claim reserves		9b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs	·	9c(1)(C)		
(D) Other expenses	<u>g</u>	9c(1)(D)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

104111

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Part III

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(E)

9c(1)(F)

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2012

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	12 or fiscal plar	n year beginning 01/01/2008	and en	iding 12/31/2008	
A Name of plan C.W. ROBERTS CONTRA	A Name of plan C.W. ROBERTS CONTRACTING, INC FLEXIBLE BENEFITS PLAN			e-digit number (PN)	501
C Plan sponsor's name a		e 2a of Form 5500	D Emplo 59-168	oyer Identification Number 33951	(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	arrier				
(I) FIN	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
58-0663085	60380	D0793	312	01/01/2008	12/31/2008
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	commissions paid. List in line 3	the agents, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid					
			2100		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	is needed to report all persons).		
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
STEVEN FALATCO			NDS END , KY 42211		
					<u> </u>
(b) Amount of sales a			and other commissions paid	(a) Organization and	
commissions pa	10557	(c) Amount	(d) Purpose		(e) Organization code
	10337	830			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
VARIOUS OTHERS	(a) Name a	VARIO		ions of fees were paid	
VARIOUS, FL 32334					
(b) Amount of sales and base Fees and other commissions paid					
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code
	4849	358			3
					<u> </u>

Schedule A (Form 5500) 20	012	Page 2 - 1	
(a) Name		or other person to whom commissions or fees were	paid
VIOTORIA ELINOL		IA CITY, FL 32405	
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
4197	136		3
(a) Nam	e and address of the agent, broker,	or other person to whom commissions or fees were	paid
SAIC INC		ILGEN RD IBUS, GA 31907	
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
3838	243		3
(a) Nam	e and address of the agent, broker,	or other person to whom commissions or fees were	paid
PAMELA FALATKO		NDLEWICK CIRCLE IA CITY, FL 32405	
(b) Amount of sales and base	F I	ees and other commissions paid	(e) Organization
commissions paid 3346	(c) Amount	(d) Purpose	code 3
3340	200		, and the second
(a) Name	e and address of the agent, broker,	or other person to whom commissions or fees were	paid
EDDIE TORRES	PO BO: MIRAM	X 6309 AR BEACH, FL 32550	
(h) Amount of color and have	F	ees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
3053	209		3
(a) Nam	e and address of the agent, broker,	or other person to whom commissions or fees were	paid
RICHARD SHOCKLEY		IEWELL DR DLD, VA 23503	
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1871	65		3
			·

Schedule A (Form 5500)	2012	Page 2 - 2	
(a) No	ma and address of the agent broke	ar other nersen to whom commissions or feed were n	aid
JM BENEFITS	PO BC	r, or other person to whom commissions or fees were p 0X 16552 MA CITY, FL 32406	aid
4		Fees and other commissions paid	4.50
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
1530	0		3
		r, or other person to whom commissions or fees were p	aid
RANDALL PUGH		HARVARD BLVD HAVEN, FL 32444	
(b) Amount of sales and base	J	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1517	0		3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were p	aid
ORI BRADSHAW	1151 V	VALDRON FERRY RD SVILLE, TX 75650	
(h) Amount of color and have	1	Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
1335	0		3
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were p	aid
(b) Amount of sales and base	I	ees and other commissions paid	(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

(c) Amount

(b) Amount of sales and base commissions paid

Fees and other commissions paid

(d) Purpose

(e) Organization code

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Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of				
_		this report.				
		nt value of plan's interest under this contract in the general account at year				
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5	
ь		acts With Allocated Funds:				
	а	State the basis of premium rates				
	L	December 2 and the country			Ch	
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
	;	Specify nature of costs				
	e	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan d	heck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
•				ion guarantee		
	u			.o guarantos		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)					
		(C) Total additions			7c(6)	0
	_	(6)Total additions			76(6)	
		otal of balance and additions (add lines 7b and 7c(6))	Γ		/u	
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		Administration charge made by carrier	7e(1)			
		3) Transferred to separate account	7e(2)			
	`	4) Other (specify below)	7e(3)			
	(T) Outor (specify below)	, 5(7)			
	ļ	•				
	(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2012	Page 4	
information may be combined for reporting purpos	of employees of the same employer(s) or members es if such contracts are experience-rated as a unit. ach carrier may be treated as a unit for purposes of	Where contracts cover individual employe
efit and contract type (check all applicable boxes)		
Health (other than dental or vision)	Dental c X Vision	d X Life insurance
Temporary disability (accident and sickness) f	Long-term disability g Supplemental ur	nemployment h Prescription drug
Stop loss (large deductible)	HMO contract k PPO contract	I Indemnity contract
✓ Other (specify) ►CANCER	,	- <u> </u>
Other (specify) FORNOLIN		
erience-rated contracts:		
Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve.	9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4)
Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))		9b(3)
(4) Claims charged		9b(4)
Remainder of premium: (1) Retention charges (on an	accrual basis)	
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	- 4.34-3	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

180290

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

m X Other (specify) ▶CANCER

Experience-rated contracts:

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(E)

9c(1)(F)

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2012

nurrought to FDICA continue 102(a)(2)				m is Open to Public Inspection			
For calendar plan year 20	12 or fiscal pla	an year beginning 01/01/2008	3	and end	ding 12/3	1/2008	
A Name of plan C.W. ROBERTS CONTRA	A Name of plan C.W. ROBERTS CONTRACTING, INC FLEXIBLE BENEFITS PLAN			B Three plan	e-digit number (PN)	•	501
	Plan sponsor's name as shown on line 2a of Form 5500 C.W. ROBERTS CONTRACTING, INC D Employer Identification Number (EIN) 59-1683951						
		ning Insurance Contract . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
LLOYD'S OF LONDON				<u>.</u>			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate null persons covered at	-		•	ontract year T
(5) 2.11	code	identification number	policy or contract		(f) F	rom	(g) To
35-1884838	NA	CXX45447	450	6	01/01/2008	3	12/31/2008
2 Insurance fee and come descending order of the		nation. Enter the total fees and to	otal commissions paid. Lis	st in line 3 t	the agents, br	okers, and o	ther persons in
(a) Total a	amount of com	nmissions paid		(b) To	tal amount of	fees paid	
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all p	ersons).			
	(a) Name	and address of the agent, broke	r, or other person to whom	commissi	ions or fees w	ere paid	
(b) Amount of sales ar	nd base	F	ees and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose	9		(e) Organization code
	(a) Name	and address of the agent, broke	r or other person to whom	commissi	ions or fees w	vere paid	
	(a) Hamo	and dadreed or the agent, broke	n, or other percent to when		10110 01 1000 11	oro para	
(b) Amount of sales ar	nd base	F	ees and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2012	Page 2 - 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	,	.,,	
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
()) !			• • • • • • • • • • • • • • • • • • • •
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	T		<u> </u>
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	, , , , , , , , , , , , , , , , , , ,		
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
•	, ,		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

		•
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Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of				
_		this report.				
		nt value of plan's interest under this contract in the general account at year				
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5	
ь		acts With Allocated Funds:				
	а	State the basis of premium rates				
	L	Describeration and the country			Ch	
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
	;	Specify nature of costs				
	e	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan d	heck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
•				ion guarantee		
	u			.o guarantos		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)					
		(C) Total additions			7c(6)	0
	_	(6)Total additions			76(6)	
		otal of balance and additions (add lines 7b and 7c(6))	Γ		/u	
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		Administration charge made by carrier	7e(1)			
		3) Transferred to separate account	7e(2)			
	`	4) Other (specify below)	7e(3)			
	(T) Outor (specify below)	, 5(7)			
	ļ	•				
	(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2012	Page 4	
information may be combined for reporting purp	up of employees of the same employer(s) or memloses if such contracts are experience-rated as a the each carrier may be treated as a unit for purpos	unit. Where contracts cover individual employ
efit and contract type (check all applicable boxes)		
Health (other than dental or vision)	b Dental c Vision	d Life insurance
Temporary disability (accident and sickness)	f Long-term disability g Supplement	tal unemployment h Prescription drug
Stop loss (large deductible)	j HMO contract k PPO contra	act I Indemnity contract
Other (specify)		
erience-rated contracts:		
Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reser	rve 9a(3)	
(4) Earned ((1) + (2) - (3))	·····	9a(4)
Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))	·	9b(3)
(4) Claims charged		9b(4)
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	0 (1)(0)	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

311665

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Experience-rated contracts:

Part III

a Premiums: (1) Amount received...... (2) Increase (decrease) in amount due but unpaid.....

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(D) 9c(1)(E)

9c(1)(F)

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

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

Service Provider Information

File as an attachment to Form 5500.

OMB No. 1210-0110

2012

This Form is Open to Public Inspection.

For calendar plan year 2012 or fiscal plan year beginning 01/01/2008	and ending 12/31/2008	
A Name of plan C.W. ROBERTS CONTRACTING, INC FLEXIBLE BENEFITS PLAN	B Three-digit plan number (PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500	D. Employer Identification Number /	EIN)
·	D Employer Identification Number (EIIN)
C.W. ROBERTS CONTRACTING, INC	59-1683951	
Part I Service Provider Information (see instructions)		_
You must complete this Part, in accordance with the instructions, to report the information recorder or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which the answer line 1 but are not required to include that person when completing the remainder of the	with services rendered to the plan or t the plan received the required disclosu	he person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compensation	on	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of thi		ible
indirect compensation for which the plan received the required disclosures (see instructions for		
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see instr		e providers who
(b) Enter name and EIN or address of person who provided you disc	Nocures on cligible indirect companys	tion
(b) Litter hame and Litt of address of person who provided you disc	Josures on engible maneet compensat	uon
(b) Enter name and EIN or address of person who provided you disc	losure on eligible indirect compensati	on
(b) Enter name and EIN or address of person who provided you disc	locures on eligible indirect compensat	ion
(b) Enter hame and Env or address of person who provided you disc	- Iosures on engible maneet compensati	
(b) Enter name and EIN or address of person who provided you disc	losures on eligible indirect compensat	ion
(.,		

Schedule C (Form 5500) 2012	Pa	age 2- 1	
(b) Enter name and FIN or a	address of person who provided vo	ou disclosures on eligible indirect co	mpensation
(4) = 110			
(b) Enter name and EIN or a	address of person who provided yo	ou disclosures on eligible indirect co	mpensation
	<u></u>	-	<u>·</u>
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	u disclosures on eligible indirect cor	mpensation
(h) =			
(D) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation

Page 3 -	1	

Schedule C (Form 5500) 2012 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) BLUE CROSS AND BLUE SHIELD OF AL 450 RIVERCHASE PKWY EAST BIRMINGHAM, AL 35244 63-0103830 (b) (c) (d) (e) (f) (h) (g) Service Relationship to Enter direct Did service provider Did indirect compensation Enter total indirect Did the service include eligible indirect Code(s) employer, employee | compensation paid receive indirect compensation received by provider give you a organization, or by the plan. If none, compensation? (sources compensation, for which the service provider excluding formula instead of plan received the required person known to be enter -0-. other than plan or plan eligible indirect an amount or compensation for which you estimated amount? a party-in-interest sponsor) disclosures? answered "Yes" to element (f). If none, enter -0-. NONE 12 403952 Yes No X Yes No Yes No (a) Enter name and EIN or address (see instructions) (b) (c) (d) (e) (f) (g) (h) Service Enter direct Did service provider Did indirect compensation Enter total indirect Did the service Relationship to Code(s) employer, employee compensation paid receive indirect include eligible indirect compensation received by provider give you a compensation, for which the organization, or formula instead of by the plan. If none compensation? (sources service provider excluding person known to be enter -0-. other than plan or plan plan received the required eligible indirect an amount or compensation for which you estimated amount? a party-in-interest sponsor) disclosures? answered "Yes" to element (f). If none, enter -0-. Yes No Yes No Yes No (a) Enter name and EIN or address (see instructions) (b) (d) (e) (f) (h) (c) (g) Service Relationship to Enter direct Did service provider Did indirect compensation Enter total indirect Did the service employer, employee compensation paid receive indirect include eligible indirect compensation received by provider give you a Code(s) organization, or by the plan. If none compensation? (sources 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-. Yes No Yes No Yes No

Page	3	-	2
² age	3	-	2

answered	I "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
			,			
(b) Service Code(s)	Relationship to employer, employer 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	
			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	
			Yes No	Yes No		Yes No
<u> </u>		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer 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

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compens	ation, by a service provider, and th	ne service provider is a fiduciary
or provides contract administrator, consulting, custodial, investment advisory, investment mar questions for (a) each source from whom the service provider received \$1,000 or more in indi provider gave you a formula used to determine the indirect compensation instead of an amou many entries as needed to report the required information for each source.	nagement, broker, or recordkeepin irect compensation and (b) each so	g services, answer the following ource 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
	(coo mendency)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe 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 ethe 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-

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

Page	6-
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Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)				
а	Name:	(complete as many entries as needed)	b EIN:		
C	Positio		B EIIV.		
d	Addres		e Telephone:		
•	/ lauro		С госрионо.		
Ex	olanatio):			
			I		
<u>a</u>	Name:		b EIN:		
d d	Position Address		e Telephone:		
u	Addies	.5.	е тетернопе.		
Ex	olanatio	n:			
а	Name:		b EIN:		
<u>C</u>	Positio				
d	Addres	SS:	e Telephone:		
Exi	olanatio				
а	Name:		b EIN:		
С	Positio	n:			
d	Addres	ss:	e Telephone:		
	olanatio	<u> </u>			
ᄓ	piariatio	i.			
а	Name:		b EIN:		
C	Positio				
d	Addres		e Telephone:		
Ex	olanatio	1:			

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), 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

2012

This Form is Open to Public Inspection

Part I Annual Report Iden	tification information	1		10/21/2000		
For calendar plan year 2012 or fiscal	plan year beginning 0	1/01/2008	and ending	12/31/2008		
	multiemployer plan;		- Received 1	mployer plan; or		
X as	single-employer plan;		a DFE (spec	cify)		
			the final ret	uvo/vonorts		
	e first return/report;			um/report, n year return/report (less t	han 12 months	
	amended return/report;		a snort plai	r year return report (1655 t		
C If the plan is a collectively-bargained	rm 5558;		automatic e	extension: X the I	DFVC program;	
	ecial extension (enter descr	intion)			, ,	
	tion - enter all requested in					
1a Name of plan			1b	Three-digit	o a	
C.W. ROBERTS CONTRAC!	ring, inc			plan number (PN)	501	
FLEXIBLE BENEFITS PLA			10	Effective date of plan		
				01/01/2007		
2a Plan sponsor's name and address, include	de room or suite number (empl	loyer, if for a single-employ	yer plan) 2b	Employer Identification N 59-1683951	Number (EIN)	
C.W. ROBERTS CONTRAC'	TING INC		20	Sponsor's telephone nu	mber	
C.W. ROBERTS CONTINUE	IIIO, IIIO			850-385-5060		
			2d	Business code (see insti	ructions)	
PO BOX 188				237310		
HOSFORD	FL 32334					
PO BOX 188						
HOSFORD	FL 32334					
Caution: A penalty for the late or incom						
Under penalties of perjury and other penalties set forth as the electronic version of this return/report, and to th	i in the instructions, I declare that I have best of my knowledge and belief, i	ave examined this return/report t is true, correct, and complete	i, including accompanying .	g schedules, statements and attac	annents, as well	
	2	1				
SIGN	2/27	ALAN	PALMER			
HERE Signature of plan administrator	r Date		Enter name of individual signing as plan administrator			
	/					
SIGN						
Signature of employer/plan sp	onsor Date	Enter nam	e of individual sign	ing as employer or plan s	ponsor	
SIGN HERE						
Signature of DFE	Date		e of individual sign			
Preparer's name (including firm name, it	f applicable) and address; in	nclude room or suite nu	ımber. (optional)	Preparer's telephone n	umber	
				(optional)		
				334- 792-2	152	
M. CRAIG SCARBROUGH				334- 134-2	1733	
MCDANIEL & ASSOCIAT	до, Р. С.					
P. O. BOX 6356	AL 36302-6	5356				
DOTHAN	ды 30302-0	,,,,,				
For Paperwork Reduction Act Notice	and OMB Control Number	s, see the instructions	for Form 5500.	F	orm 5500 (2012	

Information) - signed by the plan actuary