#### 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						
For caler	ndar plan year 2012 or fiscal plan	<u> </u>			31/2012		
A This r	eturn/report is for:	a multiemployer plan;	a multiple	e-employer plan; or			
		x a single-employer plan;	a DFE (s	pecify)			
<b>B</b> This r	eturn/report is:	the first return/report;	the final	return/report;			
		an amended return/report;	a short p	lan year return/report (les	ss than 12 m	onths).	
C If the	plan is a collectively-bargained plan	an, check here				<b>→</b> □	
<b>D</b> Chec	k box if filing under:	X Form 5558;	automati	c extension;	th	e DFVC program;	
	v	special extension (enter des	cription)				
Part I	I Basic Plan Informati	on—enter all requested informa	ation				
	e of plan	The state of the s			1b	Three-digit plan	504
	BERTS CONTRACTING, INC FL	EXIBLE BENEFITS PLAN				number (PN) ▶	501
					1c	Effective date of pl 01/01/2007	an
2a Plan	sponsor's name and address; inc	clude room or suite number (emp	oloyer, if for a single-	employer plan)	2b	Employer Identifica	ation
						Number (EIN) 59-1683951	
C.W. RC	BERTS CONTRACTING, INC				20	Sponsor's telephor	20
					20	number	ie
2272 CA	DITAL CIDCLE NE	2270 CAD	UTAL CIDCLE NE			850-385-5060	0
	PITAL CIRCLE NE ASSEE, FL 32308		ITAL CIRCLE NE SSEE, FL 32308		2d	Business code (se	е
						instructions) 237310	
						207010	
Caution	A penalty for the late or incom	unlete filing of this return/renor	t will be assessed	unlass ragsonable caus	eo is ostabli	shad	
	enalties of perjury and other penal						edules.
	its and attachments, as well as the						
SIGN	Filed with authorized/valid electro	onic signature.	08/28/2013	ALAN PALMER			
HERE	Signature of plan administrato	or	Date	Enter name of individu	al signing as	plan administrator	
SIGN							
HERE	Signature of employer/plan sp	oonsor	Date	Enter name of individu	al signing as	employer or plan sp	onsor
SIGN							
HERE	Signature of DFE		Date	Enter name of individu	al signing as	DFE	
	's name (including firm name, if a	pplicable) and address; include r	oom or suite numbe		Preparer's	telephone number	
M. CRAI	G SCARBROUGH, CPA				(optional)	334-792-2153	
	EL & ASSOCIATES, P. C.						
P. O. BO	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	<b>3b</b> 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		<b>5</b> 482
6	Number of participants as of the end of the plan year (welfare plans complet	e only lines <b>6a, 6b, 6c,</b> and <b>6d</b> ).	
а	Active participants		. <b>6a</b> 387
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 387
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	6e
f	Total. Add lines <b>6d</b> and <b>6e</b>		. 6f
g	Number of participants with account balances as of the end of the plan year complete this item)		   6g
	complete this item,		. 09
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
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List of Plan Characteristics Cod	•
h	If the plan provides welfare benefits, enter the applicable welfare feature coc	des from the List of Plan Characteristics Code	s in the instructions:
~	4A 4B 4D 4E 4F 4Q	and the list of Flath Characteristics Gode.	on the metadations.
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all tha	at apply)
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance Code section 412(e)(3)	insurance contracts
	(3) Trust	(3) Trust	modrance contracts
	(4) General assets of the sponsor	(4) X General assets of the sp	ponsor
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the number	per attached. (See instructions)
а	Pension Schedules	b General Schedules	
-	(1) R (Retirement Plan Information)	(1) H (Financial Inform	nation)
	- (a)		,
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	` ' H	nation – Small Plan)
	actuary	(3) X 3 A (Insurance Infor	,
	· —	<u> </u>	ng Plan Information)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6) G (Financial Trans	
	mornialism, signed by the plan delicary	(o) Li di indiriodi Hand	action Conformation)

# **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

r ension benefit duaranty of	Siporation		e required to provide the informat RISA section 103(a)(2).	This Fo	rm is Open to Public Inspection	
For calendar plan year 20	12 or fiscal plar	n year beginning 01/01/2012	and en	ding 12/31/2012		
A Name of plan C.W. ROBERTS CONTRA	ACTING, INC F	LEXIBLE BENEFITS PLAN		e-digit number (PN)	501	
C Plan sponsor's name a		e 2a of Form 5500	<b>D</b> Emplo 59-168	yer Identification Number 3951	(EIN)	
		ning Insurance Contract Condividual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	arrier					
	(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	<b>(g)</b> To	
47-0098400	61301	010-030063	250	01/01/2012	12/31/2012	
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 o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
9415					0	
3 Persons receiving com	3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).					
		and address of the agent, broker, o		ions or fees were paid		
ALLEN MOONEY & BAR	NES		CALHOUN ST HASSEE, FL 32301			
(b) Amount of sales a	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	(e) Organization code		
6673					3	
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
BB&T INSURANCE SER	• • •		PARK CT	ions of fees were paid		
GREENVILLE, SC 29616						
(b) Amount of sales and base Fees and other commissions paid			_			
commissions pa		(c) Amount	(d) Purpose	9	(e) Organization code	
	2742				3	
					<del> </del>	

Schedule A (Form 5500)	2012	Page <b>2 -</b> 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			
( ) ) !			• • • • • • • • • • • • • • • • • • • •			
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
	T					
(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 institut			
(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		•

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	ridual contrac	cts with each carrier ma	ay 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				
	<b>L</b>	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 <b>7b</b> and <b>7c(6)</b> )	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 <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2012		Page <b>4</b>		
If more than one contract covers the same information may be combined for reporting the entire group of such individual contract.	e group of employees of the s g purposes if such contracts a	are experience-rated a	as a unit. Where contrac	
Benefit and contract type (check all applicable boxe	es)			
a Health (other than dental or vision)	<b>b</b> X Dental	<b>c</b> Vision		<b>d</b> Life insurance
e Temporary disability (accident and sickness	) <b>f</b> Long-term disabilit	y <b>g</b> Supplei	mental unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k  PPO co		I Indemnity contract
	, rime contract	<b></b> □σ.α	THE GOL	
m ☐ Other (specify) ▶				
Experience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unp	oaid			
(3) Increase (decrease) in unearned premium	The state of the s			
(4) Earned ((1) + (2) - (3))	<del>-</del>		9a(4)	
<b>b</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	s (on an accrual basis)			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees				
(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

133467

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.) ......

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

(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

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

9c(1)(E)

9c(1)(F)

<sup>12</sup> 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

#### **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	orporation	Insurance companies are pursuant to El	e required to provide the in RISA section 103(a)(2).	formation	This For	m is Open to Public Inspection
For calendar plan year 20	12 or fiscal plar	n year beginning 01/01/2012	;	and ending 12	/31/2012	
A Name of plan C.W. ROBERTS CONTRA	ACTING, INC F	LEXIBLE BENEFITS PLAN	В	Three-digit plan number (PN	v) <b>•</b>	501
C Plan sponsor's name a C.W. ROBERTS CONTRA		e 2a of Form 5500		Employer Identific 59-1683951	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 ca	rrier					
THE LAC			(e) Approximate number	er of	Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract year	d of	From	(g) To
58-0663085	60380	D0793	316	01/01/20	12	12/31/2012
2 Insurance fee and composite descending order of the		ation. Enter the total fees and tota	commissions paid. List in	line 3 the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
33736						
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	is needed to report all pers	ons).		
<u> </u>		and address of the agent, broker, o			were paid	
STEVEN FALATCO		213 LA	NDS END , KY 42211			
(b) Amount of sales ar	nd hase	Fees	and other commissions pa	aid		
commissions pa		(c) Amount	( <b>d</b> ) F	Purpose		(e) Organization code
	14032	211				3
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
VARIOUS OTHERS						
Fees and other commissions paid						
(b) Amount of sales ar commissions pai		(c) Amount		Purpose		(e) Organization code
	6873	15				3
For Donomical Dedication	n Aat Nation :	and OMP Control Numbers, see	the instructions for Farm	. EE00	Caba	dula A (Form EE00) 2042

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1	
·		, or other person to whom commissions or fees were pa	aid
SAIC INC		IILGEN RD MBUS, GA 31907	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 3057	(c) Amount	(d) Purpose	code 3
-	31		
(a) Na	me and address of the agent, broken	, or other person to whom commissions or fees were pa	
DANIEL S ADAMS	3857 S	COTT CHURCH RD NNA, FL 32448	iid.
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1931	0		3
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were pa	aid
PAMELA FALATKO	137 CA	NDLEWICK CIRCLE //A CITY, FL 32405	
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1836	0		3
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were pa	aid
BRIAN ANDREWS	5728 T	AMARACK DR FL 32571	
	PACE,	FL 32571	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1708	47		3
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were pa	aid
ALLEN MOONEY & BARNES	318 N O TALLA	CALHOUN ST HASSEE, FL 32301	
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
1659	0		3

Schedule A	(Form	5500)	2012

VICTORIA LENCE

Page **2** - 2

<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
/ICTORIA LENCE		RVARD CIRCLE MA CITY, FL 32405	
	LANA	MA 0111,112 32400	
	,	Fees and other commissions paid	() 0
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
1424	0	(4) 1 4.5000	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
IJM BENEFITS	PO BC	OX 16552	
	PANAI	MA CITY, FL 32406	
	Г		
<b>(b)</b> Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code 3
1216	0		3
( ) ) (			
( <b>a)</b> Na	me and address of the agent, broker	r, 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
	1		
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(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
·			
<b>(a)</b> Na	ime and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Face and other commissions raid	
(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 indiv	ridual contrac	cts with each carrier ma	ay 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				
	<b>L</b>	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 <b>7b</b> and <b>7c(6)</b> )	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 <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2012	Paç	ge <b>4</b>	
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 of	oup of employees of the same employe irposes if such contracts are experience	e-rated as a unit. Where contrac	
efit and contract type (check all applicable boxes)	_		
Health (other than dental or vision)	b Dental C X	Vision	<b>d</b> X Life insurance
Temporary disability (accident and sickness)	f Long-term disability g	Supplemental unemployment	<b>h</b> Prescription drug
Stop loss (large deductible)	j HMO contract k	PPO contract	I Indemnity contract
Other (specify)  CANCER			
erience-rated contracts:			
Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium res	erve 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 (o	n an accrual basis)		
(A) Commissions			
(B) Administrative service or other fees			
(C) Other specific acquisition costs	2 (1)(2)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

220265

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:

a Health (other than dental or vision)

m X Other (specify) ▶CANCER

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

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

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions ..... (B) Administrative service or other fees ..... (C) Other specific acquisition costs..... (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)

<sup>12</sup> 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

#### **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	Pension Benefit Guaranty Corporation  ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).  This Fo			m is Open to Public Inspection		
For calendar plan year 20°	12 or fiscal pla	an year beginning 01/01/201	2	and ending	12/31/2012	
A Name of plan C.W. ROBERTS CONTRACTING, INC FLEXIBLE BENEFITS PLAN			B Three-digi		501	
C Plan sponsor's name as shown on line 2a of Form 5500 C.W. ROBERTS CONTRACTING, INC  D Employer Identification Number 59-1683951				(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						
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		-	ontract year T
(5) 2.11	code	identification number	policy or contract		(f) From	<b>(g)</b> To
06-1041332	93440	403299	38	01	/01/2012	12/31/2012
2 Insurance fee and comp descending order of the		nation. Enter the total fees and t	total commissions paid. Li	st in line 3 the a	gents, brokers, and o	ther persons in
(a) Total a	amount of com	nmissions paid		(b) Total ar	mount of fees paid	
		0				0
3 Persons receiving com		fees. (Complete as many entri				
\/=\=\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	(a) Name	and address of the agent, broke	er, or other person to whor 06 CAHABA RD SUITE B	n commissions of	or fees were paid	
YEARY & MOORE LLC			MINGHAM, AL 35223			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pai		(c) Amount	(	(d) Purpose		(e) Organization code
	0					3
	(a) Name	and address of the agent, broke	er, or other person to whor	n commissions o	or fees were paid	
		<b>.</b>				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose		(e) Organization code

Schedule A (Form 5500)	2012	Page <b>2 -</b> 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
( ) ) !			• • • • • • • • • • • • • • • • • • • •
<b>(a)</b> 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 institut
(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

		•
חבי	Δ	- 5
ay		•

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	ridual contrac	cts with each carrier ma	ay 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				
	<b>L</b>	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 <b>7b</b> and <b>7c(6)</b> )	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 <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2012		Page <b>4</b>		
,		- 3-		
Welfare Benefit Contract Informat		omployor(o) or	mambara af tha aama an	onloves organizations(s) the
If more than one contract covers the same guinformation may be combined for reporting p				
the entire group of such individual contracts				
efit and contract type (check all applicable boxes)				
Health (other than dental or vision)	<b>b</b> Dental	<b>C</b> Vision		<b>d</b> Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g Supple	emental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k  PPO c	contract	I Indemnity contract
Other (specify)		<u></u>		ш .
_ c.i.e. (opeciny)				
erience-rated contracts:				
Premiums: (1) Amount received	98	a(1)		
(2) Increase (decrease) in amount due but unpaid	j98	a(2)		
(3) Increase (decrease) in unearned premium res	erve9a	a(3)		
(4) Earned ((1) + (2) - (3))	<u></u>		9a(4)	
Benefit charges (1) Claims paid	9t	o(1)		
(2) Increase (decrease) in claim reserves	9t	o(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
Remainder of premium: (1) Retention charges (c	n an accrual basis)			
(A) Commissions	9c(	1)(A)		
(B) Administrative service or other fees	9c(	1)(B)		
(C) Other specific acquisition costs	9c(	1)(C)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

691717

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.....

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions..... (B) Administrative service or other fees ...... (C) Other specific acquisition costs..... (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			
<b>11</b> 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)

<sup>12</sup> 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 **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

2012

This Form is Open to Public Inspection.

For calendar plan year 2012 or fiscal plan year beginning 01/01/2012	and ending 12/31/2012
A Name of plan C.W. ROBERTS CONTRACTING, INC FLEXIBLE BENEFITS PLAN	<b>B</b> Three-digit 501
C.W. ROBERTS CONTRACTING, INC FLEXIBLE BENEFITS FLAN	plan number (PN)
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
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 inform or more in total compensation (i.e., money or anything else of monetary value) in cor	
plan during the plan year. If a person received <b>only</b> eligible indirect compensation for	
answer line 1 but are not required to include that person when completing the remain	nder of this Part.
1 Information on Persons Receiving Only Eligible Indirect Comp	ensation
a Check "Yes" or "No" to indicate whether you are excluding a person from the remain	
indirect compensation for which the plan received the required disclosures (see instr	
<b>b</b> 16	and the state of t
b If you answered line 1a "Yes," enter the name and EIN or address of each person preceived only eligible indirect compensation. Complete as many entries as needed (	, ,
(b) Enter name and EIN or address of person who provided	d you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	d you disclosure on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	d you disclosures on eligible indirect compensation
(1) 2.110. 110.110 2.11 2.11 2.1 20.1000 3.1 poison 1110 provides	, you would also also also mailed to mpolication.
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation

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

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
		(	a) Enter name and EIN or	address (see instructions)		
BLUE CRO	SS AND BLUE SHIEL	LD OF AL		RCHASE PKWY EAST HAM, AL 35244		
63-0103830						
(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	NONE	325022	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
		(	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

Page	3	-	2
-age	J	-	12

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?	(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

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 mondono)	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 <b>5-</b>
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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	rt III	Termination Information on Accountants and Enrolled Actuaries (see ins	structions)					
a	Name:	(complete as many entries as needed)	<b>b</b> EIN:					
C	Positio		B EIIV.					
d	Addres		<b>e</b> Telephone:					
•	/ ladio		С госраново.					
Ex	olanatio	):						
_	Nicon		h rivi					
<u>a</u>	Name:		b EIN:					
d d	Position Address		<b>e</b> Telephone:					
u	Addie	is.	С тегерпопе.					
Ex	olanatio	n:						
a	Name:		<b>b</b> EIN:					
C	Positio							
d	Addres	SS:	e Telephone:					
Exi	olanatio	);						
а	Name:		<b>b</b> EIN:					
С	Positio	n:						
d	Addres	ss:	<b>e</b> Telephone:					
Evi	olanatio	<u> </u>						
ᅜᄭ	piariatio	l.						
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		Identification in		0010		10/21/2012	
For calend	dar plan year 2012 o	fiscal plan year begin		2012 an	d ending	12/31/2012	
A This return	n/report is for:	a multiemployer p  X a single-employer			4	employer plan; or cify)	
B This retur		the first return/rep	n/report;		1	turn/report; n year return/report (less t	han 12 months
			'e		i	П и	
D Check bo	x if filing under:	X Form 5558;		L	automatic	extension;	DFVC program;
Down II	Basic Blan Info	special extension ormation - enter all	(enter description)				
Part II	The state of the s	officer and	requested information		1b	Three-digit	
1a Name of	BERTS CONT	RACTING, IN	rC .			plan number (PN)	501
	E BENEFITS				10	Effective date of plan 01/01/2007	
2a Plan spor	sor's name and addres	s, include room or suite	number (employer, if for a	single-employer pla	an) 2b	Employer Identification N	Number (EIN)
C.W. RC	BERTS CONT	RACTING, IN	IC			Sponsor's telephone nu 0 – 385 – 5060	mber
3372 CA	PITAL CIRC	LE NE			2d	Business code (see instr 237310	ructions)
TALLAHA 3372 CA	ASSEE APITAL CIRC	FL LE NE	32308				
TALLAHA		FL	32308		. 1		
Under penalties o	f periury and other penalties	s set forth in the instructions,		this return/report, inclu		able cause is established ng schedules, statements and attac	
as the close office	01			T			
SIGN	ellen (	To hu	8/28/17	ALAN PAI	MER		
HERE Signa	ature of plan admin	istrator	Date	Enter name of i	ndividual sigr	ning as plan administrator	
SIGN							
HERE	ature of employer/p	lan sponsor	Date	Enter name of i	ndividual sigr	ning as employer or plan s	ponsor
SIGN							
HERE Sign	ature of DFE		Date	Enter name of i	ndividual sigr	ning as DFE	
The second secon		name, if applicable) an	d address; include roor	m or suite number	r. (optional)	Preparer's telephone n (optional)	umber
	AIG SCARBRO		_			334- 792-2	153
	EL & ASSOC BOX 6356	CIATES, P. (	C.				
DOTHAL		AL 3	36302-6356				
For Paperwo	ork Reduction Act N	lotice and OMB Cont	rol Numbers, see the	instructions for	Form 5500.		orm 5500 (2012 120126

За	Plan administrator's name and address 🛛 Same as Plan Sponsor Name 🗓 Same a	onsor Name 🗵 Same as Plan Sponsor Address   3b Administrator's EIN							
	3c Administra						ator's telephone number		
4	If the name and/or EIN of the plan sponsor has changed since the last retu	rn/report	filed fo	r this plai	n, enter the nam	10,	4b EIN		
	EIN and the plan number from the last return/report:						40 00		
а	Sponsor's name						4c PN		
5	Total number of participants at the beginning of the plan year					5	482		
6	Number of participants as of the end of the plan year (welfare plans completed)	ete only lir	nes 6a.	6b, 6c, a	ınd <b>6d</b> ).				
-	Active participants					6a	387		
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					<u>6d</u>	387		
е	Deceased participants whose beneficiaries are receiving or are entitled to r	eceive be	nefits		.,,,	6e			
f	Total. Add lines 6d and 6e					6f			
g	Number of participants with account balances as of the end of the plan year					   6g			
h	complete this item)  Number of participants that terminated employment during the plan year w	ith accuse	d hon	afite that	ware less than	Ug			
"	100% vested					6h			
7	Enter the total number of employers obligated to contribute to the plan (on								
	complete this item)	-				7			
8a	If the plan provides pension benefits, enter the applicable pension feature	codes fro	m the l	ist of Pla	n Characteristic	s Coo	des in the instructions:		
b	If the plan provides welfare benefits, enter the applicable welfare feature of	odes from	the Li	st of Plan	Characteristics	Code	s in the instructions:		
4A	4B 4D 4E 4F 4Q								
Qa.	Plan funding arrangement (check all that apply)  98	) Plan he	enefit s	rrangem	ent (check all th	at anr	nlvl		
ou	(1) X Insurance	(1)		urance	one (or look all th	ut upp	··)1		
	(2) Code section 412(e)(3) Insurance contracts	(2)	¬,		n 412(e)(3) insui	ance	contracts		
	(3) Trust	(3)	Tru		,				
	(4) A General assets of the sponsor	(4)			ets of the spons				
10	Check all applicable boxes in 10a and 10b to indicate which schedules are (See instructions)	attached	, and,	where inc	licated, enter th	e num	ber attached.		
а	Pension_Schedules	b Gener	ral Sci	nedules					
	(1) R (Retirement Plan Information)	(1)	_	н	(Financial Info				
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	_	<u>,</u> 1	•		on - Small Plan)		
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X	<u>3</u> A	(Insurance Inf		•		
	actuary	(4)	<u> </u>	C	(Service Provi		-		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	-	D			Plan Information)		
	Information) - signed by the plan actuary	(6)		G	(Financial Trai	rsacti	on Schedules)		