### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2010

1 611310	on Benefit Guaranty Corporation				This Form is Open to Pu Inspection	ublic	
Part I	Annual Report Iden	tification Information					
For cale	ndar plan year 2010 or fiscal p			and ending 12/01/2	2011		
A This	return/report is for:	a multiemployer plan;	a multip	le-employer plan; or			
		X a single-employer plan;	a DFE (	specify)			
		<u>_</u>	_				
<b>B</b> This	return/report is:	the first return/report;	the final	return/report;			
		an amended return/report;	a short	olan year return/report (less th	nan 12 months).		
<b>C</b> If the	plan is a collectively-bargaine	ed plan, check here					
D Chec	k box if filing under:	Form 5558;	automa	tic extension;	the DFVC program;		
2 000	voxg uuo	special extension (enter des					
Part	II Rasic Plan Inform	nation—enter all requested inform	. ,				
	ne of plan	ination—enter an requested inform	alion		<b>1b</b> Three-digit plan	501	
	•	D & LIFE INSURANCE PLAN			number (PN) ▶	501	
					1c Effective date of plan		
					12/01/2010		
	n sponsor's name and addres: ress should include room or s	s (employer, if for a single-employer	plan)		<b>2b</b> Employer Identification Number (EIN)		
	NDENT COACH CORP.	suite no.)			11-1556334		
IIIDEI E	TIBERT CONOTTOOR				2c Sponsor's telephone		
					number		
	SER AVENUE	25 WANS	SER AVENUE		516-239-1100		
INWOOI	D, NY 11096	INWOOD	), NY 11096		2d Business code (seinstructions)	е	
					485210		
Caution	· A nonalty for the late or in	complete filing of this return/repo	ert will be assessed	unloss rossonable cause is	e ostablishod		
		· · · · · · · · · · · · · · · · · · ·				dules	
	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.						
SIGN	Filed with authorized/valid ele	ectronic signature.	09/12/2013	MICHAEL FABRIZIO			
HERE	Signature of plan adminis	trator	Date	Enter name of individual si	igning as plan administrator		
	Orginature or plan adminis	uuu	Date	Enter Hame of marvidual 5	igning as plan administrator		
SIGN							
HERE	Signature of ampleyer/pla	in chancar	Data	Enter name of individual of	igning as amplayor or plan an	oncor	
	Signature of employer/pla	iii əpulləui	Date	Enter name or individual s	igning as employer or plan sp	10011001	
SIGN							
HERE							

Date

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

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

	Form 5500 (2010)	Page	e <b>2</b>		
	Plan administrator's name and address (if same as plan sponsor, enter "Sar	me")			Iministrator's EIN
	WANSER AVENUE VOOD, NY 11096			nu	Iministrator's telephone Imber 6-239-1100
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for f	this plan, enter the name, EIN	N and	4b EIN
а	Sponsor's name				4c PN
5	Total number of participants at the beginning of the plan year			5	336
6	Number of participants as of the end of the plan year (welfare plans complete	te only lines 6a, 6	<b>6b, 6c,</b> and <b>6d</b> ).		•
а	Active participants			6a	336
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			6c	
d	Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>			6d	336
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive 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 witless than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only	y multiemployer p	olans complete this item)	. 7	
	If the plan provides pension benefits, enter the applicable pension feature code  f the plan provides welfare benefits, enter the applicable welfare feature code  4B 4Q  Plan funding arrangement (check all that apply)  (1) Insurance	es from the List o		n the ins	tructions:
	(2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor	(2) (3) (4)	Code section 412(e)(3) Trust General assets of the s		ce contracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a			<u> </u>	ched. (See instructions)
2	Pension Schedules	h General	Schadulas		

(1)

(2)

(3)

(4)

(5)

(6)

**H** (Financial Information)

A (Insurance Information)C (Service Provider Information)

I (Financial Information – Small Plan)

**D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

R (Retirement Plan Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(1)

(2)

(3)

# **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

2010

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			111101	This Form is Open to Public Inspection			
For calendar plan year 20	10 or fiscal pla	n year beginning 12/01/2010	and e	nding 12/01/2011			
A Name of plan INDEPENDENT COACH	CORP. AD&D	& LIFE INSURANCE PLAN		e-digit number (PN)	501		
C Plan sponsor's name a INDEPENDENT COACH	CORP.		11-155				
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		PANY					
	(-) NIAIO	(A) October of the	(e) Approximate number of	Policy or	contract year		
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To		
13-1595128	62243	GLCL0AHJF	336	12/01/2010	12/01/2011		
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item 3	3 the agents, brokers, and	d other persons in		
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		1726			688		
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all persons).				
	(a) Name a	and address of the agent, broker, o					
CENTERSTONE INS AN	D FINAN		WESTCHESTER AVENUE STE S E PLAINS, NY 10604-3512	3229			
(b) Amount of sales ar		Fees	s and other commissions paid				
commissions pa	id	(c) Amount (d) Purpose			(e) Organization code		
	1726	0 AG	AGENT OR BROKER OF RECORD 3				
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	sions or fees were paid			
CENTERSTONE INS AN	D FINAN		VESTCHESTER AVENUE STE S E PLAINS, NY 10604-3512	3229			
(b) Amount of sales ar	nd base	Fees	s and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code		
	0	688 OT	HER COMPENSATION		5		
For Paperwork Reductio	n Act Notice a	and OMB Control Numbers, see	the instructions for Form 5500.	. So	chedule A (Form 5500) 20		

Schedule A (Form 5500)	2010	Page <b>2-</b>					
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid				
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid				
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid				
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid				
		Fees and other commission	an noid				
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code			
	(o) runount		(a) i dipoco				
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
	• •						
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base	(b) Amount of sales and base Fees and other commissions paid (e) Organization						
commissions paid	(c) Amount		(d) Purpose	code			

Pa	art II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual report.	dual contracts with each o	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year er		1 _ 1	
6	Cont	racts With Allocated Funds:		<u> </u>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount	•	1 60 1	
		Specify nature of costs •			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan check here	<b>•</b> []	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accou	nts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(o) guaranteed investment (i) guaranteed			
		<b>5</b> .1		71.	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	<b>-</b> (a)		
		(3) Interest credited during the year	- (4)		
		(4) Transferred from separate account	7c(5)		
		(5) Other (specify below)	70(3)		
		•			
		(6)Total additions		7c(6)	0
	ď	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )		7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			
		, , , , , , , , , , , , , , , , , , , ,			

Page	4

P	art III	weitare Benefit Contract Informa						
		If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experience	ce-rated as a unit. W	here contrac		es,
8	Benefit	t and contract type (check all applicable boxes)	)					
	_	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> X Life insurance	
		Temporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental uner	mplovment	h Prescription drug	
	- =	Stop loss (large deductible)	j HMO contract	-, s_ k□	PPO contract		I Indemnity contract	
		Other (specify)	, Livio contract		110 contract		I Indemnity contract	
	□	Other (specify)						
<u>a</u>	Evporio	ence-rated contracts:						
3	•	emice-rated contracts. emiums: (1) Amount received		. 9a(1)			_	
		) Increase (decrease) in amount due but unpai					_	
	` '	) Increase (decrease) in unearned premium re		2 (2)			-	
	` '	) Earned ((1) + (2) - (3))				9a(4)		
	_	enefit charges (1) Claims paid				5000 5000	0	
		) Increase (decrease) in claim reserves		21 (2)			-	
	` '	) Incurred claims (add (1) and (2))				9b(3)	5	000
	` '	) Claims charged						
	` '	emainder of premium: (1) Retention charges (				<u>JD(4)</u>		
	• 10	(A) Commissions	,	9c(1)(A)			-	
		(B) Administrative service or other fees		9c(1)(B)			-	
		(C) Other specific acquisition costs		9c(1)(C)			_	
		(D) Other expenses		9c(1)(D)			-	
		(E) Taxes		0 (4)(5)			_	
		(F) Charges for risks or other contingencies		0 (4)(5)			_	
		(G) Other retention charges		2 (1)(2)				
		(H) Total retention				9c(1)(H	)	
	(2	2) Dividends or retroactive rate refunds. (These					<u>'</u>	
		tatus of policyholder reserves at end of year: (						
		2) Claim reserves				· · · · ·		
		3) Other reserves				9d(2)		
	,	ividends or retroactive rate refunds due. (Do r						
10		experience-rated contracts:	iot include amount emere	a iii <b>c(z)</b> .)		36		
•		otal premiums or subscription charges paid to	carrier			10a	13	3754
	_	the carrier, service, or other organization incur						
		etention of the contract or policy, other than rep				10b		
	Spec	cify nature of costs						
Р	art IV	Provision of Information						
1		ne insurance company fail to provide any inform	nation necessary to comp	lete Schadula	Δ2	Yes	No	
	י טוע נו	to modification company fall to provide any lillon	nation necessary to comp	TOTO CONTEGUIE	/ \ i			

# **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

2010

			RISA section 103(a)(2).	Inis Fo	rm is Open to Public Inspection
For calendar plan year 20	10 or fiscal plan	year beginning 12/01/2010	and er	nding 12/01/2011	
A Name of plan INDEPENDENT COACH	CORP. AD&D (	& LIFE INSURANCE PLAN		e-digit number (PN)	501
C Plan sponsor's name a INDEPENDENT COACH	CORP.		11-155		. ,
		ing Insurance Contract C Individual contracts grouped as a			
1 Coverage Information:					
(a) Name of insurance ca		MPANY			
	(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
47-0246511	71412	MP 0AHJF	336	12/01/2010	12/01/2011
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in item 3	the agents, brokers, and	other persons in
(a) Total a	amount of comn	·	<b>(b)</b> To	otal amount of fees paid	
		94			38
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).		
		nd address of the agent, broker, o			
CENTERSTONE INS AN	D FINAN		VESTCHESTER AVENUE STE S FPLAINS, NY 10604-3512	229	
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpose	(e) Organization code	
	94	0 AG	ENT OR BROKER OF RECORD		3
	(a) Name a	nd address of the agent, broker, c			
CENTERSTONE INS AN	D FINAN		VESTCHESTER AVENUE STE S PLAINS, NY 10604-3512	229	
(b) Amount of sales ar	nd hase	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code
	0	38 OTI	HER COMPENSATION		5
For Panerwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500	Sci	edule A (Form 5500) 20

Schedule A (Form 5500)	2010	Page <b>2-</b>					
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid				
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid				
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid				
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid				
		Fees and other commission	an noid				
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code			
	(o) runount		(a) i dipoco				
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
	• •						
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base	(b) Amount of sales and base Fees and other commissions paid (e) Organization						
commissions paid	(c) Amount		(d) Purpose	code			

Pa	art II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual report.	dual contracts with each o	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year er		1 _ 1	
6	Cont	racts With Allocated Funds:		<u> </u>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount	•	1 60 1	
		Specify nature of costs •			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan check here	<b>•</b> []	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accou	nts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(o) guaranteed investment (i) guaranteed			
		<b>5</b> .1		71.	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	<b>-</b> (a)		
		(3) Interest credited during the year	- (4)		
		(4) Transferred from separate account	7c(5)		
		(5) Other (specify below)	70(3)		
		•			
		(6)Total additions		7c(6)	0
	ď	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )		7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			
		, , , , , , , , , , , , , , , , , , , ,			

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Pa	rt II	Welfare Benefit Contract Informati If more than one contract covers the same gro information may be combined for reporting put the entire group of such individual contracts w	up of employees of the s poses if such contracts a	re experienc	e-rated as a unit. Whe	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	, g	Supplemental unemp	loyment	h Prescription drug
	i Ē		j HMO contract	, 5 <u> </u>	PPO contract	,	I Indemnity contract
	. L	Other (specify) ACCIDENTAL DEATH AND I		·` _	117 O contract		■ Indemnity contract
	m	Other (specify)					
9	Evno	rience-rated contracts:					
,		Premiums: (1) Amount received	Г	9a(1)			
	u	(2) Increase (decrease) in amount due but unpaid	F	9a(2)			
		(3) Increase (decrease) in unearned premium rese	T T	9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves	F				
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )	_			9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on				(-/	
	_	(A) Commissions	·	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs	F	9c(1)(C)			
		(D) Other expenses	-   -   -   -   -   -   -   -   -   -	9c(1)(D)			
		(E) Taxes	T .	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges	T	9c(1)(G)			
		(H) Total retention	<del>-</del>			9c(1)(H)	)
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	include amount entered	in <b>c(2)</b> .)		9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	750
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report				10b	
	Sp	ecify nature of costs					
P	rt I	/ Provision of Information					
			tion nonconcerta as a la	to Calcadele	Λ2 Π	Yes	No
11	טוט	I the insurance company fail to provide any informa	mon necessary to comple	ele Scheanle	Α:	1 63	□ 140

### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

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

➤ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210 - 0110 1210 - 0089

2010

This Form is Open to Public Inspection

Part I Annual Report Identification In	nformation							
For calendar plan year 2010 or fiscal plan year begi	nning 12/01/	2010 and end	ing 12/01/2011					
A This return/report is for:  a multiemployer page a single-employer page a single-employer page as a single-employer page	a multiple-employer plan; or gle-employer plan; or a DFE (specify)							
B This return/report is:		the final return/report; a short plan year return/report (less than 12 months)						
C If the plan is a collectively-bargained plan, check he	•		<b></b> `					
D Check box if filing under: Form 5558;	(enter description)	aut	omatic extension; X the DFVC program;					
Part II Basic Plan Information · enter all			<u>-</u>					
1a Name of plan INDEPENDENT COACH CORP. AD&I		URANCE PLAN	1b Three-digit plan number (PN) ► 501  1c Effective date of plan 12/01/2010					
2a Plan sponsor's name and address (employer, if for (Address should include room or suite no.)	2b Employer Identification Number (EIN) 11-1556334							
INDEPENDENT COACH CORP.	•	2c Sponsor's telephone number 516-239-1100						
25 WANSER AVENUE			2d Business code (see instructions) 485210					
INWOOD NY 25 WANSER AVENUE	11096							
INWOOD NY	11096		(1) 建聚化 美国家的 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)					
Caution: A penalty for the late or incomplete filing of	this return/report will	be assessed unless re	easonable cause is established.					
Under penalties of perjury and other penalties set forth in the instructions, is the electronic version of this return/report, and to the best of my knowle			ompanying schedules, statements and attachments, as well					
SIGN HERE MICHA								
Signature of play administrator	Date	Enter name of individu	ual signing as plan administrator					
SIGN HERE								
Signature of employer/plan sponsor	Date	Enter name of individu	ual signing as employer or plan sponsor					
SIGN HERE								
Signature of DFE	Date	Enter name of individu	me of individual signing as DFE					

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

Form 5500 (2010) V.092307.1

	Form 5500 (2010)		Pa	ige <b>2</b>				
3a Plan administrator's name and address (If same as plan sponsor, enter "Same") SAME			rator's EIN					
						ator's telephone number		
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the nar EIN and the plan number from the last return/report:							
а	Sponsor's name					4c PN		
5	Total number of participants at the beginning of the plan year				5		33	
6	Number of participants as of the end of the plan year (welfare plans co			-				
	Active participants				6a		33	
	Retired or separated participants receiving benefits				6b 6c			
ч С					6d	_	336	
	d Subtotal. Add lines 6a, 6b, and 6c  e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits							
f	Total. Add lines 6d and 6e				6e 6f			
g	Number of participants with account balances as of the end of the plar							
complete this item)					6g			
h	h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested							
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans							
Ва	If the plan provides pension benefits, enter the applicable pension feature.				7 Code	s in the instru	ıctions:	
ь 4В	If the plan provides welfare benefits, enter the applicable welfare featur $4Q$	e codes from the Lis	t of Plan (	Characteristic (	Codes	in the instruc	tions:	
)a	Plan funding arrangement (check all that apply)	nt (check all th	at app	ly)				
	XInsurance(1)XInsurance(2)Code section 412(e)(3) insurance contracts(2)Code section 412(e)(3) insurance							
	(2) Code section 412(e)(3) insurance contracts	ance c	contracts					
	(3) Trust (4) General assets of the sponsor							
10	(4) General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)			ts of the spons cated, enter the		ber attached.		
а	Pension Schedules	b General Scho	edules					
	(1) R (Retirement Plan Information)	(1)	н	(Financial Info	rmation	n)		
	2) MB (Multiemployer Defined Benefit Plan and Certain Money (2) I (Financial Inform						)	
	Purchase Plan Actuarial Information) - signed by the plan	ormatio						
	actuary	der Info	ormation)					
	(3) SB (Single-Employer Defined Benefit Plan Actuarial							
		(6) G (Financial Transaction Schedules)						