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	Part I Annual Report Identification Information							
For cale	ndar plan year 2010 or fiscal p			and ending 12/31/20	10			
A This	eturn/report is for:	a multiemployer plan;	a multip	e-employer plan; or				
		a single-employer plan;	a DFE (specify)				
				· · · · · · · · · · · · · · · · · · ·				
B This	return/report is:	the first return/report;	the final	return/report;				
	otani, roport io.	an amended return/report;	<u>—</u>	plan year return/report (less tha	ın 12 months).			
C 15 41- a		d plan, check here	_					
D Chec	k box if filing under:	Form 5558;	automat	ic extension;	the DFVC program;			
		special extension (enter desc	cription)					
Part	II Basic Plan Inform	ation—enter all requested informa	ation					
1a Nam	ne of plan				1b Three-digit plan	501		
PERKIN	S EASTMAN ARCHITECTS H	EALTH & WELFARE PLAN			number (PN) ▶			
					1c Effective date of plants of plant	an		
		(employer, if for a single-employer p	plan)		2b Employer Identification			
`	ress should include room or su	,			Number (EIN)			
PERKIN	S EASTMAN ARCHITECTS P	C			13-3044005			
					2c Sponsor's telephone number			
					212-353-7200			
	TH AVENUE DRK, NY 10003		115 FIFTH AVENUE NEW YORK, NY 10003			е		
	,		,		instructions)			
					541310			
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.								
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.								
SIGN	Filed with authorized/valid elec	ctronic signature.	10/18/2013	CANDACE CARROLL				
HERE	Cignoture of plan administ		Data	Enter name of individual sig	ning on plan administrator			
	Signature of plan administ	I ALUI	Date	Enter name of individual sig	ning as pian auministrator			
SIGN	Filed with authorized/valid ele	ctronic signature	10/18/2013	CANDACE CARROLL				
HERE	i ilea witti autilolizeu/valla elei	stronic signature.	10/10/2013	5 15/102 5/11(10EE				

Date

Date

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

Signature of employer/plan sponsor

Signature of DFE

SIGN **HERE**

> Form 5500 (2010) v.092307.1

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

Form 5500 (2010) Page **2**

	Plan administrator's name and address (if same as plan sponsor, enter "Same RKINS EASTMAN ARCHITECTS PC)		Iministrator's EIN 3044005		
	5 FIFTH AVENUE W YORK, NY 10003		nu	ministrator's telephone imber 2-353-7200		
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:	report filed for this plan, enter the name, EIN	l and	4b EIN		
а	Sponsor's name			4c PN		
5	Total number of participants at the beginning of the plan year		5	614		
6	Number of participants as of the end of the plan year (welfare plans complete	only lines 6a, 6b, 6c, and 6d).				
а	Active participants		. 6a	448		
b	Retired or separated participants receiving benefits		. 6b	49		
С	Other retired or separated participants entitled to future benefits		. 6c	0		
d	Subtotal. Add lines 6a, 6b, and 6c		. 6d	497		
е	Deceased participants whose beneficiaries are receiving or are entitled to receive	eive benefits	. 6е	0		
f	Total. Add lines 6d and 6e		. 6f	497		
g	Number of participants with account balances as of the end of the plan year (complete this item)	·	. 6g	0		
h	Number of participants that terminated employment during the plan year with less than 100% vested		. 6h	0		
7	Enter the total number of employers obligated to contribute to the plan (only r	nultiemployer plans complete this item)	. 7			
	a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A 4B 4D 4E 4F 4H 4Q					
9a 10	(1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor	9b Plan benefit arrangement (check all the (1)	insurand	ce contracts		
	Check all applicable boxes in 10a and 10b to indicate which schedules are attempted. Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) H (Financial Inform (2) I (Financial Inform (3) 8 A (Insurance Inform (4) C (Service Provide (5) D (DFE/Participati (6) G (Financial Trans	nation) nation – mation) er Inform ng Plan	Small Plan) nation) Information)		

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

nursuant to EDICA agetion 402(a)(2)					m is Open to Public Inspection	
For calendar plan year 20	10 or fiscal plai	n year beginning 01/01/2010)	and ending	12/31/2010	•
A Name of plan PERKINS EASTMAN AR	CHITECTS HE	ALTH & WELFARE PLAN	В	Three-digit plan number	(PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500. PERKINS EASTMAN ARCHITECTS PC D Employer Identification Number (E						
		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca	rrier				D. II.	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate numb persons covered at er	nd of	Policy or co	(g) To
22-2777159	47029	12136870	policy or contract ye		1/2010	12/31/2010
2 Insurance fee and complete descending order of the		ation. Enter the total fees and to	tal commissions paid. List i	n item 3 the age	ents, brokers, and c	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
						0
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).						
• r ereene recenning com		and address of the agent, broke			ees were paid	
SINGER NELSON CHAR		108	6 TEANECK ROAD NECK, NJ 07666		·	
(b) Amount of sales ar	nd base	F	ees and other commissions p	paid		
commissions pai		(c) Amount	•	(d) Purpose		
1534		0		·		3
	(a) Name a	and address of the agent, broke	r, or other person to whom c	ommissions or f	ees were paid	
(b) Amount of sales and base Fees and other commissions paid				() 0		
commissions pa	ıd	(c) Amount	(d)	Purpose		(e) Organization code

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

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts v	with each carrier may be trea	ted as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	0
		ent value of plan's interest under this contract in separate accounts at year e			0
_		racts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			0
	С	Premiums due but unpaid at the end of the year		<u>6c</u>	0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		. 60	0
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferrer (3) other (specify)	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan chec	k here	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation	guarantee	
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		0
		(2) Dividends and credits	. 7c(2)		0
		(3) Interest credited during the year	. 7c(3)		0
		(4) Transferred from separate account	. 7c(4)		0
		(5) Other (specify below)	. 7c(5)		0
		•			
		(6)Total additions			
	ď	Total of balance and additions (add b and c(6))		7d	0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		0
		(2) Administration charge made by carrier	7e(2)		0
		(3) Transferred to separate account	_ ` /		0
		(4) Other (specify below)	. 7e(4)		0
		>			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract e(5) from d)			0

Page	4

Pa	rt I	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	roup of employees of the urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contract		∋s,
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabili	ity g	Supplemental unem	ployment	h Prescription drug	
	i [Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Ехр	erience-rated contracts:						
	a [·]	Premiums: (1) Amount received		. 9a(1)		0		
		(2) Increase (decrease) in amount due but unpaid	d	. 9a(2)		0		
		(3) Increase (decrease) in unearned premium res	serve	9a(3)		0		
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	b	Benefit charges (1) Claims paid		. 9b(1)		0		
		(2) Increase (decrease) in claim reserves		. 9b(2)		0		
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		0
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				_	
		(A) Commissions				0	_	
		(B) Administrative service or other fees				0		
		(C) Other specific acquisition costs				0	_	
		(D) Other expenses				0	_	
		(E) Taxes						
		(F) Charges for risks or other contingencies		A (4)(A)		0		
		(G) Other retention charges				0		0
		(H) Total retention	_			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		0
	d	Status of policyholder reserves at end of year: (1	,			9d(1)		0
		(2) Claim reserves				9d(2)		0
		(3) Other reserves				9d(3)		0
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entere	d in c(2) .)		. 9e		0
10		nexperience-rated contracts:					200	150
	a	Total premiums or subscription charges paid to c				10a	30	6459
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,		•	10b		0
	Sp	pecify nature of costs						

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

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation			t to ERISA section 103(a)(2).			m is Open to Public Inspection
For calendar plan year 201	0 or fiscal plan	year beginning 01/01/2010	;	and ending 12	/31/2010	
A Name of plan PERKINS EASTMAN ARC	CHITECTS HE	ALTH & WELFARE PLAN	В	Three-digit plan number (Pl	N) •	501
C Plan sponsor's name as PERKINS EASTMAN ARC		e 2a of Form 5500.		Employer Identific 13-3044005	cation Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance car GUARDIAN		(d) Contract or	(e) Approximate numbe	r of	Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract year	(1)	From	(g) To
13-5123390	64246	00318670	228	01/01/20)10	12/31/2010
2 Insurance fee and commodescending order of the		ation. Enter the total fees and total	al commissions paid. List in	item 3 the agents	, brokers, and c	other persons in
(a) Total a	mount of comr			(b) Total amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all perso	ons).		0
• 1 crooms receiving comm		nd address of the agent, broker,			were naid	
SINGER NELSON CHAR		1086	TEANECK ROAD ECK, NJ 07666			
(b) Amount of sales an	d base	Fee	s and other commissions pa	iid		
commissions pai		(c) Amount	(d) P	urpose		(e) Organization code
	5670	0 AD	DITIONAL FEES			3
	(a) Name a	nd address of the agent, broker,	or other person to whom cor	mmissions or fees	were paid	
	(a) Name a	na address of the agent, broker,	or earler person to whom ear		, were paid	
(b) Amount of sales and base Fees and other commissions paid						
commissions pai		(c) Amount	(d) P	(d) Purpose		(e) Organization code

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

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts v	with each carrier may be trea	ted as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	0
		ent value of plan's interest under this contract in separate accounts at year e			0
_		racts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			0
	С	Premiums due but unpaid at the end of the year		<u>6c</u>	0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		. 60	0
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferrer (3) other (specify)	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan chec	k here	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation	guarantee	
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		0
		(2) Dividends and credits	. 7c(2)		0
		(3) Interest credited during the year	. 7c(3)		0
		(4) Transferred from separate account	. 7c(4)		0
		(5) Other (specify below)	. 7c(5)		0
		•			
		(6)Total additions			
	ď	Total of balance and additions (add b and c(6))		7d	0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		0
		(2) Administration charge made by carrier	7e(2)		0
		(3) Transferred to separate account	_ ` /		0
		(4) Other (specify below)	. 7e(4)		0
		>			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract e(5) from d)			0

Page	4

	art II	If more than one contract covers the same grinformation may be combined for reporting puthe entire group of such individual contracts of	oup of employees of the surposes if such contracts	are experien	ce-rated as a unit	 Where contract 	
8	Ben	efit and contract type (check all applicable boxes)	_	_	_		_
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	ty g	Supplemental u	inemployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I ndemnity contract
	m	Other (specify)		_	_		
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)		0	
	_	(2) Increase (decrease) in amount due but unpaid				0	
		(3) Increase (decrease) in unearned premium res				0	1
		(4) Earned ((1) + (2) - (3))		· · · · · · · · · · · · · · · · · · ·		9a(4)	0
	b	Benefit charges (1) Claims paid				0	
		(2) Increase (decrease) in claim reserves		9b(2)		0	
		(3) Incurred claims (add (1) and (2))				9b(3)	0
		(4) Claims charged				9b(4)	0
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)		T		_
		(A) Commissions		9c(1)(A)		0	
		(B) Administrative service or other fees		9c(1)(B)		0	
		(C) Other specific acquisition costs				0	
		(D) Other expenses		9c(1)(D)		0	
		(E) Character for right or other continuous		- (1)(-)		0	
		(F) Charges for risks or other contingencies.		2 (1)(2)		0	
		(G) Other retention charges(H) Total retention				9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These					0
	٨		ш :	LI			0
	d	Status of policyholder reserves at end of year: (1 (2) Claim reserves					0
		(3) Other reserves					0
	е	Dividends or retroactive rate refunds due. (Do n					0
10	_	enexperience-rated contracts:	ot morado amount omoroc	z 0(_).,			
	а	Total premiums or subscription charges paid to o	arrier			10a	244648
	b	If the carrier, service, or other organization incur					
		retention of the contract or policy, other than repe					0
	Sp	pecify nature of costs					

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Co		pursuant to ERISA section 103(a)(2).				m is Open to Public Inspection		
For calendar plan year 20	10 or fiscal pla	an year beginning 01/01/201	0	and er	nding 12	/31/2010		
A Name of plan PERKINS EASTMAN AR	CHITECTS HE	EALTH & WELFARE PLAN			e-digit number (P	N) •	501	
C Plan sponsor's name a PERKINS EASTMAN AR				D Emplo		cation Number (EIN)	
		ning Insurance Contrac Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca		CE, INC.						
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
23-7391136	55093	376235	6	637)10	12/31/2010	
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Parsons receiving com	missions and	135236 fees. (Complete as many entrie		nercone)			0	
J Fersons receiving com					iono or food	. wara naid		
SINGER NELSON CHAR			66, TEANECK ROAD ANECK, NJ 07666	III COIIIIIIISS	ions or rees	s were palu		
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	135236	0					3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code	

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	with each carrier may be trea	ted as a unit for purposes of	
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	0
		ent value of plan's interest under this contract in separate accounts at year e			0
_		racts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			0
	С	Premiums due but unpaid at the end of the year		<u>6c</u>	0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		. 60	0
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferrer (3) other (specify)	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan chec	k here	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation	guarantee	
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		0
		(2) Dividends and credits	. 7c(2)		0
		(3) Interest credited during the year	. 7c(3)		0
		(4) Transferred from separate account	. 7c(4)		0
		(5) Other (specify below)	. 7c(5)		0
		•			
		(6)Total additions			
	ď	Total of balance and additions (add b and c(6))		7d	0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		0
		(2) Administration charge made by carrier	7e(2)		0
		(3) Transferred to separate account	_ ` /		0
		(4) Other (specify below)	. 7e(4)		0
		>			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract e(5) from d)			0

Page	4
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Pa	rt I	I Welfare 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	roup of employees of the sourposes if such contracts	are experience	ce-rated as a unit. Wh	ere contracts	
8	Ben	efit and contract type (check all applicable boxes))				
	а	Health (other than dental or vision)	b ☐ Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	olovment	h ☐ Prescription drug
	i	Stop loss (large deductible)	j HMO contract	, s k		, ,	I Indemnity contract
	m	Other (specify)	,] • ••		
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		. 9a(1)		0	
		(2) Increase (decrease) in amount due but unpai	id	. 9a(2)		0	
		(3) Increase (decrease) in unearned premium re-	serve	. 9a(3)		0	
		(4) Earned ((1) + (2) - (3))				9a(4)	0
	b	Benefit charges (1) Claims paid		. 9b(1)		0	
		(2) Increase (decrease) in claim reserves		. 9b(2)		0	
		(3) Incurred claims (add (1) and (2))				9b(3)	0
		(4) Claims charged				9b(4)	0
	С	Remainder of premium: (1) Retention charges (,				
		(A) Commissions		9c(1)(A)		0	
		(B) Administrative service or other fees				0	
		(C) Other specific acquisition costs				0	
		(D) Other expenses		9c(1)(D)		0	
		(E) Taxes				0	
		(F) Charges for risks or other contingencies				0	
		(G) Other retention charges		9c(1)(G)		0	
		(H) Total retention	<u></u>	<u></u>		9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid ir	n cash, or	credited.)	9c(2)	0
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	0
		(2) Claim reserves				9d(2)	0
		(3) Other reserves				9d(3)	0
	е	Dividends or retroactive rate refunds due. (Do r	not include amount entered	d in c(2) .)		9e	0
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to	carrier			10a	2410436
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	, ,		•	10b	0
	S	ecify nature of costs					

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

r ension benefit duaranty of	orporation	Insurance companies ai pursuant to El	This Fo	This Form is Open to Public Inspection				
For calendar plan year 20								
A Name of plan PERKINS EASTMAN AR	CHITECTS HE	ALTH & WELFARE PLAN		e-digit number (PN)	501			
C Plan sponsor's name as shown on line 2a of Form 5500. PERKINS EASTMAN ARCHITECTS PC D Employer Identification Number 13-3044005					(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		COMPANY						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	•	contract year			
(,	code	identification number	policy or contract year	(f) From	(g) To			
36-2598882	71129	FNYH893193	448 11/01/2009		10/31/2010			
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item 3	the agents, brokers, and	other persons in			
(a) Total	amount of com		(b) To	otal amount of fees paid				
		2594			0			
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	or other person to whom commiss	ions or fees were paid				
SINGER NELSON CHAR	RLMERS INC.		EANECK ROAD ECK, NJ 07666					
(b) Amount of sales a	nd hase	Fees	and other commissions paid					
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code			
	2594	0			3			
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid				
	(4)							
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount	(d) Purpose	(e) Organization code				

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	with each carrier may be trea	ted as a unit for purposes of	
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	0
		ent value of plan's interest under this contract in separate accounts at year e			0
_		racts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			0
	С	Premiums due but unpaid at the end of the year		<u>6c</u>	0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		. 60	0
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferrer (3) other (specify)	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan chec	k here	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation	guarantee	
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		0
		(2) Dividends and credits	. 7c(2)		0
		(3) Interest credited during the year	. 7c(3)		0
		(4) Transferred from separate account	. 7c(4)		0
		(5) Other (specify below)	. 7c(5)		0
		•			
		(6)Total additions			
	ď	Total of balance and additions (add b and c(6))		7d	0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		0
		(2) Administration charge made by carrier	7e(2)		0
		(3) Transferred to separate account	_ ` /		0
		(4) Other (specify below)	. 7e(4)		0
		>			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract e(5) from d)			0

Page	4
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Part III

Part IV

Welfare Benefit Contract Information

a Health e Tempo i Tempo i Stop lo m Other (9 Experience-ra a Premiums (2) Increa (3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	s: (1) Amount received	b		9a(1) 9a(2) 9a(3)	Vision Supplemental uner PPO contract	(d \(\text{Life insurance} \) h \(\text{Prescription drug} \) I \(\text{Indemnity contract} \)
a Health e Tempo i Tempo i Stop lo m Other (9 Experience-ra a Premiums (2) Increa (3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	(other than dental or vision) rary disability (accident and sickness) ss (large deductible) specify) ▶ AD&D ted contracts: s: (1) Amount received	b	Long-term disal	bility g k 9a(1) 9a(2) 9a(3)	Supplemental uner	(h Prescription drug I Indemnity contract
e Tempo i Stop lo m Other (9 Experience-ra a Premiums (2) Increa (3) Increa (4) Earne (5) Increa (6) Increa (7) Increa (8) Incurr (9) Claim C Remaince (A) C	rary disability (accident and sickness) ss (large deductible) specify) AD&D ted contracts: s: (1) Amount received	f	Long-term disal	bility g k 9a(1) 9a(2) 9a(3)	Supplemental uner	(h Prescription drug I Indemnity contract
i Stop lo m Other (9 Experience-ra a Premiums (2) Increa (3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	ss (large deductible) specify) AD&D ted contracts: s: (1) Amount received	j	HMO contract	9a(1) 9a(2) 9a(3)	=	(I Indemnity contract
m Other (9 Experience-ra a Premiums (2) Increa (3) Increa (4) Earne (5) Benefit c (6) Increa (7) Increa (8) Incurr (9) Claim C Remainc (A) C	specify) AD&D ted contracts: s: (1) Amount received	idserve		9a(1) 9a(2) 9a(3)	PFO CONTIACT	(0
9 Experience-ra a Premiums (2) Increa (3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	ted contracts: as: (1) Amount received	idserve		9a(2) 9a(3)		(0
a Premiums (2) Increa (3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	s: (1) Amount received	idserve		9a(2) 9a(3)		(0
a Premiums (2) Increa (3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	s: (1) Amount received	idserve		9a(2) 9a(3)		(0
(2) Increa (3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	ase (decrease) in amount due but unpaidase (decrease) in unearned premium resed ((1) + (2) - (3))	idserve		9a(2) 9a(3)			
(3) Increa (4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	ase (decrease) in unearned premium reserved ((1) + (2) - (3))	serve		9a(3)		(
(4) Earne b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	ed ((1) + (2) - (3))						0
b Benefit c (2) Increa (3) Incurr (4) Claim c Remainc (A) C	charges (1) Claims paidase (decrease) in claim reservesed claims (add (1) and (2))s charged					9a(4)	0
(2) Increa (3) Incurr (4) Claim C Remaind (A) C	ase (decrease) in claim reservesed claims (add (1) and (2))s charged					<u> 34(+)</u>)
(3) Incurr (4) Claim c Remaind (A) C	red claims (add (1) and (2))s charged					(0
(4) Claim C Remaind (A) C	s charged					9b(3)	0
C Remaind	3					(1)	0
(A) C				•••••	•••••	30(4)	
` '	der of premium: (1) Retention charges (c			9c(1)(A)		(0
	Commissions Idministrative service or other fees					(0
` '	Other specific acquisition costs			2 (4)(2)		(0
` '	Other expenses			2 (1)(2)		(0
` ,	axes			0 (4)(5)		(0
()	charges for risks or other contingencies.			2 (1)(=)		(
	Other retention charges					(0
. ,	otal retention					9c(1)(H)	0
` '	ends or retroactive rate refunds. (These		_	_			0
							0
	f policyholder reserves at end of year: (1	•	•				0
` '	reserves						0
` '	r reserves						0
	ls or retroactive rate refunds due. (Do n	iot includ	de amount ente	rea in c(2) .)		9e	
•	nce-rated contracts:					100	20132
_	emiums or subscription charges paid to o					10a	23.102
	rier, service, or other organization incur of the contract or policy, other than rep	•	•		•	10b	0
	ure of costs		,	2010, 10po.1 a			

X No

Yes

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

Provision of Information

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).				orm is Open to Public Inspection		
For calendar plan year 20	10 or fiscal plan	n year beginning 01/01/2010	and er	nding 12/31/2010		
A Name of plan PERKINS EASTMAN AR	CHITECTS HE	ALTH & WELFARE PLAN		e-digit number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500. PERKINS EASTMAN ARCHITECTS PC D Employer Identification Number (EIN) 13-3044005						
on a separat		ning Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca		PANY				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or	contract year	
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To	
13-1898173	64297	906564	198	12/01/2009	11/30/2010	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item 3	the agents, brokers, and	d other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
5348 825						
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons).			
-		and address of the agent, broker, o		ions or fees were paid		
SINGER NELSON CHAR		1086 T	EANECK ROAD ECK, NJ 07666	·		
(b) Amount of sales a	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code	
	5348	825 AD	DITIONAL COMPENSATION		3	
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid		
	(4)					
(b) Amount of sales a	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code	

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

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

Page	4
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Pa	If more than one contract covers the same grant information may be combined for reporting process the entire group of such individual contracts of the entire group of the entire	oup of employees of the urposes if such contracts	are experienc	ce-rated as a unit. Whe	ere contracts	
8		•	leateu as a u	The for purposes of this	тероп.	
	a Health (other than dental or vision)	b Dental	сГ	Vision	(Life insurance
	Temporary disability (accident and sickness)	f Long-term disabili	<u> </u>	Supplemental unemp		Prescription drug
		님 ·	•	4	ioyinent i	. H
	i Stop loss (large deductible)	j HMO contract	k_	PPO contract		Indemnity contract
	m ☐ Other (specify) ► AD&D					
9	Experience-rated contracts:					
	a Premiums: (1) Amount received		9a(1)		0	
	(2) Increase (decrease) in amount due but unpaid	b	9a(2)		0	
	(3) Increase (decrease) in unearned premium res	serve	9a(3)		0	
	(4) Earned ((1) + (2) - (3))				9a(4)	0
	b Benefit charges (1) Claims paid				0	
	(2) Increase (decrease) in claim reserves				0	
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged				9b(4)	0
	C Remainder of premium: (1) Retention charges (c	,	0-(4)(A)		0	
	(A) Commissions		9c(1)(A)		0	
	(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)		0	
	(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)		0	
	(E) Taxes		9c(1)(E)		0	
	(F) Charges for risks or other contingencies.		9c(1)(F)		0	
	(G) Other retention charges				0	
	(H) Total retention				9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These	_		i	9c(2)	0
	d Status of policyholder reserves at end of year: (1			•	9d(1)	0
	(2) Claim reserves	•			9d(2)	0
	(3) Other reserves			l	9d(3)	0
	e Dividends or retroactive rate refunds due. (Do n				9e	0
10	Nonexperience-rated contracts:					
	a Total premiums or subscription charges paid to o	arrier			10a	36473
	b If the carrier, service, or other organization incurretention of the contract or policy, other than repr			'	10b	0
	Specify nature of costs ▶					

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

For calendar plan year 2010 or fiscal plan year beginning O1001/2010 B There-digit plan number (PN)	pursuant to ERISA section 103(a)(2).				m is Open to Public Inspection		
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information (a) Name of insurance carrier FIRST UNUM LIFE INSURANCE COMPANY (b) EIN (c) NAIC code Identification number period of Identification number of periodic covered at end of periodic covered at end of periodic covered at end of policy or contract year periodic or contrac	For calendar plan year 20	10 or fiscal pla	n year beginning 01/01/2010		and ending 1	2/31/2010	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier FIRST UNUM LIFE INSURANCE COMPANY (b) EIN	•	CHITECTS HE	EALTH & WELFARE PLAN	В	3 -	PN)	501
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Coverage Information:							EIN)
(a) Name of insurance carrier FIRST UNUM LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number persons covered at end of persons covered at end of policy or contract year 13-1898173 (64297) 906564 198 12/01/2010 12/31/2010 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	on a separat						
(e) Approximate number of persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons of the amount persons in information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 141 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 1086 TEANECK ROAD TEANECK, NJ 07666 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 141 ADDITIONAL COMPENSATION 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 141 ADDITIONAL COMPENSATION 3 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (e) Organization code (f) Amount (f) Purpose (f) Amo	1 Coverage Information:						
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 1086 TEANECK ROAD TEANECK, NJ 07666 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	3 Persons receiving com	missions and t	ees. (Complete as many entries	as needed to report all pers	sons).		
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code			· /				(e) Organization code
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code		844	141 AD	DITIONAL COMPENSATION	ON		3
commissions paid (c) Amount (d) Purpose (e) Organization code		(a) Name	and address of the agent, broker,	or other person to whom co	ommissions or fee	es were paid	
commissions paid (c) Amount (d) Purpose (e) Organization code							
commissions paid (c) Amount (d) Purpose (e) Organization code	(b) Amount of sales ar	nd hase	Fee	s and other commissions p	aid		
	` ,		(c) Amount	(d)	Purpose		(e) Organization code
For Departurally Paduation Act Nation and OMP Control Numbers, see the instructions for Form FEOD Schoolule A (Form FEOD) 2010							adula A (Form FF00) 2010

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

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

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Part III

Welfare Benefit Contract Information

		If more than one contract covers the same group of information may be combined for reporting purpose the entire group of such individual contracts with ea	s if such contracts a	are experi	enc	e-rated as a unit. Whe	ere contract	
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) b	Dental	c	;∏	Vision		d X Life insurance
	еĪ	Temporary disability (accident and sickness) f		v c	ıΠ	Supplemental unemp	lovment	h Prescription drug
	ιĖ	Stop loss (large deductible)	HMO contract	_	, ה	PPO contract	,	I Indemnity contract
	' L		TIMO CONTRACT	r	`□	FFO Contract		I I indemnity contract
	m [Other (specity)						
9 1	Ехрє	erience-rated contracts:						
	a i	Premiums: (1) Amount received		9a(1)			0	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			0	
		(3) Increase (decrease) in unearned premium reserve					0	
		(4) Earned ((1) + (2) - (3))					9a(4)	0
	b	Benefit charges (1) Claims paid		9b(1)			0	
		(2) Increase (decrease) in claim reserves		9b(2)			0	
		(3) Incurred claims (add (1) and (2))					9b(3)	0
		(4) Claims charged					9b(4)	0
	С	Remainder of premium: (1) Retention charges (on an a	ccrual basis)					
		(A) Commissions		9c(1)(A			0	
		(B) Administrative service or other fees		9c(1)(B			0	
		(C) Other specific acquisition costs		9c(1)(C	_		0	
		(D) Other expenses	•	9c(1)(D	_		0	
		(E) Taxes	l l	9c(1)(E	_		0	_
		(F) Charges for risks or other contingencies	li i	9c(1)(F) 9c(1)(G			0	
		(G) Other retention charges	-					0
		(H) Total retention	_		_		9c(1)(H)	0
	_1	(2) Dividends or retroactive rate refunds. (These amou		<u> </u>	_		9c(2)	0
	d	Status of policyholder reserves at end of year: (1) Amo					9d(1)	0
		(2) Claim reserves					9d(2)	0
	_	(3) Other reserves					9d(3)	0
10		Dividends or retroactive rate refunds due. (Do not inclunexperience-rated contracts:	ude amount entered	in C(2).) .			9e	
10		Total premiums or subscription charges paid to carrier					10a	3977
	_	If the carrier, service, or other organization incurred an					IVa	
		retention of the contract or policy, other than reported in	, ,			•	10b	0
	Sp	ecify nature of costs	•	•				•
Pa	rt I\	/ Provision of Information						
11	Dic	I the insurance company fail to provide any information	necessary to compl	ete Sched	ule	A?	Yes	X No
12	If th	ne answer to line 11 is "Yes." specify the information no	t provided.					

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

r ension benefit dualanty of	orporation		re required to provide the informat RISA section 103(a)(2).	This Fo	This Form is Open to Public Inspection			
For calendar plan year 20	10 or fiscal plar	n year beginning 01/01/2010	and er	nding 12/31/2010				
A Name of plan PERKINS EASTMAN AR	CHITECTS HE	ALTH & WELFARE PLAN		e-digit number (PN)	501			
C Plan sponsor's name a PERKINS EASTMAN AR			D Emplo	oyer Identification Number	(EIN)			
on a separat	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		PANY						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or o	contract year			
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To			
13-1898173	64297	906755	428	12/01/2009	11/30/2010			
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item 3	the agents, brokers, and	other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid								
2369								
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons).					
		and address of the agent, broker, of		ions or fees were paid				
SINGER NELSON CHAR		1086 7	EANECK ROAD ECK, NJ 07666	·				
(b) Amount of sales a	nd hase	Fees	and other commissions paid					
commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code			
		328 AD	DITIONAL COMPENSATION		3			
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid				
		, , , , , , , , , , , , , , , , , , ,		,				
(b) Amount of sales a	nd hase	Fees	s and other commissions paid					
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code			

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

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts v	with each carrier may be trea	ted as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	0
		ent value of plan's interest under this contract in separate accounts at year e			0
_		racts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			0
	С	Premiums due but unpaid at the end of the year		<u>6c</u>	0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		. 60	0
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan chec	k here	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation	guarantee	
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		0
		(2) Dividends and credits	. 7c(2)		0
		(3) Interest credited during the year	. 7c(3)		0
		(4) Transferred from separate account	. 7c(4)		0
		(5) Other (specify below)	. 7c(5)		0
		•			
		(6)Total additions			
	ď	Total of balance and additions (add b and c(6))		7d	0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		0
		(2) Administration charge made by carrier	7e(2)		0
		(3) Transferred to separate account	_ ` /		0
		(4) Other (specify below)	. 7e(4)		0
		>			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract e(5) from d)			0

Page	4

a	If more than one contract covers the same grinformation may be combined for reporting priction the entire group of such individual contracts of and contract type (check all applicable boxes). Health (other than dental or vision). Temporary disability (accident and sickness). Stop loss (large deductible). Other (specify). ence-rated contracts: emiums: (1) Amount received	urposes if such contracts with each carrier may be to b Dental f Long-term disabilities HMO contract	are experience reated as a u	ce-rated as a unit. When the control of this vision	ere contracts report.	
a	Health (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify) ence-rated contracts: emiums: (1) Amount received	b Dental f Long-term disabilit j HMO contract	ty g	Supplemental unem		Prescription drug
e	Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify) ence-rated contracts: emiums: (1) Amount received	f Long-term disabilities HMO contract	ty g	Supplemental unem		Prescription drug
i	Stop loss (large deductible) Other (specify) ence-rated contracts: emiums: (1) Amount received	j HMO contract			ployment I	
9 Experie a Pre (2 (3 (4 b B	Other (specify) • ence-rated contracts: emiums: (1) Amount received	, L	k [PPO contract		I Indemnity contract
9 Experie a Pre (2 (3 (4 b B	Other (specify) • ence-rated contracts: emiums: (1) Amount received	, L				
9 Experie a Pre (2 (3) (4 b B	ence-rated contracts: emiums: (1) Amount received 2) Increase (decrease) in amount due but unpaid					
a Pre (2 (3 (4 b B	emiums: (1) Amount received?) Increase (decrease) in amount due but unpaid					
a Pre (2 (3 (4 b B	emiums: (1) Amount received?) Increase (decrease) in amount due but unpaid					
(3 (4 b B			9a(1)		0	
(4 b B	3) Increase (decrease) in unearned premium res	d			0	
b B		serve	9a(3)		0	
	l) Earned ((1) + (2) - (3))				9a(4)	0
	Benefit charges (1) Claims paid		9b(1)		0	
(2	2) Increase (decrease) in claim reserves		9b(2)		0	
(3	3) Incurred claims (add (1) and (2))				9b(3)	0
,	l) Claims charged				9b(4)	0
C R	Remainder of premium: (1) Retention charges (c		0 (4)(4)		0	
	(A) Commissions		9c(1)(A)		0	
	(B) Administrative service or other fees		9c(1)(B)		0	
	(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)		0	
	(D) Other expenses(E) Taxes		9c(1)(E)		0	
	(F) Charges for risks or other contingencies.		9c(1)(F)		0	
	(G) Other retention charges		2 (1)(2)		0	
	(H) Total retention				9c(1)(H)	0
(2	2) Dividends or retroactive rate refunds. (These	_	_			0
	Status of policyholder reserves at end of year: (1	_			9d(1)	0
	2) Claim reserves	· •			9d(2)	0
`	3) Other reserves				9d(3)	0
,	Dividends or retroactive rate refunds due. (Do n				9e	0
	experience-rated contracts:		. , ,		JI.	
a T	otal premiums or subscription charges paid to o	carrier			10a	13125
	the carrier, service, or other organization incurretention of the contract or policy, other than rep				10b	0
Spec	cify nature of costs					

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

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

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

r ension benefit duaranty of	Siporation		re required to provide the informate RISA section 103(a)(2).	tion This Fo	This Form is Open to Public Inspection			
For calendar plan year 20	10 or fiscal plan	n year beginning 01/01/2010	and e	nding 12/31/2010				
A Name of plan PERKINS EASTMAN AR	CHITECTS HE	ALTH & WELFARE PLAN		e-digit number (PN)	501			
C Plan sponsor's name a PERKINS EASTMAN AR			D Emplo	oyer Identification Number 14005	(EIN)			
on a separat	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		PANY						
(b) FI NI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year			
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To			
12-1898173	64297	906755	428	428 12/01/2010				
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in item 3	the agents, brokers, and	other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid								
642								
3 Persons receiving com	missions and fo	ees. (Complete as many entries a	as needed to report all persons)					
• 1 crooms receiving com		and address of the agent, broker, o		ions or fees were naid				
SINGER NELSON CHAR		1086 T	TEANECK ROAD ECK, NJ 07666	iono on reeds were paid				
43.4		Face	s and other commissions paid					
(b) Amount of sales an commissions pa		(c) Amount	·	(d) Purpose (e) Orga				
1			DITIONAL COMPENSATION		3			
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were naid	•			
	(a) Name a	ind address of the agent, broker, t	or other person to whom commiss	ions of fees were paid				
(b) Amount of sales a	nd hase	Fees	s and other commissions paid					
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code			

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

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts v	with each carrier may be trea	ted as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	0
		ent value of plan's interest under this contract in separate accounts at year e			0
_		racts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			0
	С	Premiums due but unpaid at the end of the year		<u>6c</u>	0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		. 60	0
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan chec	k here	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation	guarantee	
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		0
		(2) Dividends and credits	. 7c(2)		0
		(3) Interest credited during the year	. 7c(3)		0
		(4) Transferred from separate account	. 7c(4)		0
		(5) Other (specify below)	. 7c(5)		0
		•			
		(6)Total additions			
	ď	Total of balance and additions (add b and c(6))		7d	0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		0
		(2) Administration charge made by carrier	7e(2)		0
		(3) Transferred to separate account	_ ` /		0
		(4) Other (specify below)	. 7e(4)		0
		>			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract e(5) from d)			0

Page	4
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Part III

Welfare Benefit Contract Information

		information may be combined for reporting put the entire group of such individual contracts with the entire group of the entire group of such individual contracts with the entire group of the entire group	irposes if such cont	racts are experi	enc	e-rated as a unit. Whe	ere contracts	
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	c	;∏	Vision	(d X Life insurance
	e	Temporary disability (accident and sickness)	f Long-term di	isability 9	ıΠ	Supplemental unemp	oloyment I	h Prescription drug
	iΓ	Stop loss (large deductible)	j HMO contrac	_	ָ ֡֞֝֞֞֞֜֡֞֝֡֡֡֡֡	PPO contract	·	I Indemnity contract
	m	Other (specify) AD&D	,		- Ш			
	∟	Cuter (specify)						
9	Expe	rience-rated contracts:						
_		Premiums: (1) Amount received		9a(1)			0	
		(2) Increase (decrease) in amount due but unpaid					0	
		(3) Increase (decrease) in unearned premium res		- :-:			0	
		(4) Earned ((1) + (2) - (3))					9a(4)	0
	_	Benefit charges (1) Claims paid					0	
		(2) Increase (decrease) in claim reserves		(-)			0	
		(3) Incurred claims (add (1) and (2))					9b(3)	0
		(4) Claims charged					9b(4)	0
		Remainder of premium: (1) Retention charges (o						
		(A) Commissions			.)		0	
		(B) Administrative service or other fees			_		0	
		(C) Other specific acquisition costs		0. (4)(0	_		0	
		(D) Other expenses		9c(1)(D)		0	
		(E) Taxes		9c(1)(E)		0	
		(F) Charges for risks or other contingencies		9c(1)(F))		0	
		(G) Other retention charges		9c(1)(G	i)		0	
		(H) Total retention					9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These	amounts were	oaid in cash, or	С	redited.)	9c(2)	0
	d	Status of policyholder reserves at end of year: (1	_	_	_		9d(1)	0
	-	(2) Claim reserves	•				9d(2)	0
		(3) Other reserves					9d(3)	0
	е	Dividends or retroactive rate refunds due. (Do no					9e	0
10		nexperience-rated contracts:		······································				
		Total premiums or subscription charges paid to c	arrier				10a	7517
	_	If the carrier, service, or other organization incurr						
		retention of the contract or policy, other than repo					10b	0
	Sp	ecify nature of costs						
	•	•						
Pa	rt I\	Provision of Information						

X No

Yes

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010	and ending 12/31/2010	
A Name of plan PERKINS EASTMAN ARCHITECTS HEALTH & WELFARE 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)
PERKINS EASTMAN ARCHITECTS PC	13-3044005	. ,
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in connecti plan during the plan year. If a person received only eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of	on with services rendered to the plan or ch the plan received the required disclos	the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compensation	ation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of		
indirect compensation for which the plan received the required disclosures (see instruction	s for definitions and conditions)	Yes 🛚 No
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 in	•	ce providers who
(b) Enter name and EIN or address of person who provided you of	lisclosures on eligible indirect compensa	ation
(b) Enter name and EIN or address of person who provided you	disclosure on eligible indirect compensate	tion
(b) Enter name and EIN or address of person who provided you d	isclosures on eligible indirect compensa	ation
(b) Enter name and EIN or address of person who provided you d	isclosures on eligible indirect compensa	ation

	Schedule C (Form 5500) 2010	Page 2-	
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the control of th	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
1	(b) Enter name and EIN or address of person wi	ho provided you disclosures on eligible ind	irect compensation

answered	I "yes" to line 1a above	e, complete as many e	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 to	otal compensation
-		(a) Enter name and EIN or	address (see instructions)		
22-2615990	ANALYSIS, INC.					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	8768	Yes No X	Yes No 🖺	0	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

	Schedule C (Form 5500) 2010			Page 4-		
		(a) Enter name and EIN or	address (see instructions)		
		`	<u>.,</u>			
(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 No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or	Enter direct compensation paid by the plan. If none,	(e) Did service provider receive indirect compensation? (sources	(f) Did indirect compensation include eligible indirect compensation, for which the	Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of

other than plan or plan

sponsor)

Yes No

plan received the required

disclosures?

Yes No

person known to be

a party-in-interest

enter -0-.

eligible indirect

compensation for which you answered "Yes" to element

(f). If none, enter -0-.

an amount or

estimated amount?

Yes No

Part I Service Provider Information (continued)		
3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment may questions for (a) each source from whom the service provider received \$1,000 or more in increase provider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	anagement, broker, or recordkeepindirect compensation and (b) each so	g services, answer the following burce for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

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Schedule C (Form 5500) 2010

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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.	4 Provide, to the extent possible, the following information for each service provider 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			

Schedule C (Form 5500) 2010	

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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
а	Name:	·	b EIN:	
С	Positio	n:		
d	Addres	s:	e Telephone:	
Ex	planatior	:		
a	Name:		b EIN:	
C	Positio	n:		
d	Addres		e Telephone:	
Fx	planatior	<u> </u>		
_^	₋	.		
а	Name:		b EIN:	
c	Positio	n:		
d	Addres		e Telephone:	
			•	
Ex	planatior	:		
а	Name:		b EIN;	
С	Positio	n:		
d	Addres		e Telephone:	
Ex	planatior	:		
<u>a</u>	Name:		b EIN;	
С	Positio			
d	Addres	s:	e Telephone:	
Ex	planatior	i.		