#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110 1210-0089

2013

This Form is Open to Public Inspection

1 011310	on Benefit Guaranty Gorporation					Inspection		
Part I	Annual Report Identific	cation Information						
For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013								
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or				
71 11110	ctaninoport io ior.	a single-employer plan;						
X a single-employer plan;								
_		The first actions to a cut-	П нь - £ 1 -					
<b>B</b> This	return/report is:	the first return/report;		return/report;				
		an amended return/report;	a short p	lan year return/report (les	s than 12 m	onths).		
<b>C</b> If the	plan is a collectively-bargained pl	an, check here				. ▶ □		
	k box if filing under:	Form 5558;	X automati		_	e DFVC program;		
D Chec	k box ii iiiiiig diidei.	<u>'</u>	<u> </u>	o extension,	□ "'	c Di vo piogiaiii,		
		special extension (enter desc	<u> </u>					
Part	II   Basic Plan Informati	on—enter all requested informa	ition		ı		•	
	ne of plan				1b	Three-digit plan	501	
C.W. RO	BERTS CONTRACTING, INC FL	EXIBLE BENEFITS PLAN			4.5	number (PN) ▶		
					10	Effective date of plants o	an	
<b>30</b> Di-					26		4'	
<b>Za</b> Plar	sponsor's name and address; inc	dude room or suite number (emp	ployer, if for a single-	employer plan)	20	Employer Identifica Number (EIN)	ation	
CW PO	DBERTS CONTRACTING, INC					59-1683951		
0.77.100	DERTO CONTRACTING, INC				2c	Sponsor's telephor	ne	
						number		
2270.04	DITAL CIDCLE NE	0070 040	ITAL OIDOLENE			850-385-5060	)	
	PITAL CIRCLE NE ASSEE, FL 32308		ITAL CIRCLE NE SSEE, FL 32308		2d Business code (see		е	
	,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0011, 1 01000			instructions)		
						237310		
Coution	A nonalty for the late or incom	unlata filing of this return/rener	t will be accessed	unlaca raacanahla asua	o io ostabli	chad		
	: A penalty for the late or incom						alsal a a	
	enalties of perjury and other penal nts and attachments, as well as th							
	The diffe difference, do well do in			I	501101, 1010	140, 0011001, 4114 0011	ipioto.	
OLON								
SIGN HERE	Filed with authorized/valid electron	onic signature.						
IILKE	Signature of plan administrate	or	Date	Enter name of individua	al signing as	plan administrator		
SIGN								
HERE	Signature of ampleyor/plan or		Date	Enter name of individua	l oigning on	omployer er plen en	oncor	
	Signature of employer/plan sp	onsor	Date	Enter name of individua	al signing as	employer or plan sp	OTISOI	
CION		ļ						
SIGN HERE								
IILIXL	Signature of DFE		Date	Enter name of individua	al signing as	DFE		
•	's name (including firm name, if a	pplicable) and address; include re	oom or suite numbe	r. (optional)		telephone number		
M. CRAI	G SCARBROUGH, CPA				(optional)	334-792-2153		
MCDAN	IEL & ASSOCIATES, P. C.					0017022100		
PORC	)X 6356							
	N, AL 36302-6356							
P. O. BO	OX 6356							

	Form 5500 (2013)	Page	2		
3a	Plan administrator's name and address Same as Plan Sponsor Name	Same as Plan	Sponsor Address	<b>3b</b> Administr	ator's EIN
				3c Administr	ator's telephone
4	If the name and/or EIN of the plan sponsor has changed since the last retu EIN and the plan number from the last return/report:	urn/report filed for	this plan, enter the name,	4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year			5	387
6	Number of participants as of the end of the plan year (welfare plans compl	ete only lines 6a,	<b>6b, 6c,</b> and <b>6d</b> ).		
а	Active participants			. 6a	252
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			. 6c	
d	Subtotal. Add lines 6a, 6b, and 6c			. 6d	252
е	Deceased participants whose beneficiaries are receiving or are entitled to	receive 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 w			6h	
7	Enter the total number of employers obligated to contribute to the plan (on	ly multiemployer p	plans complete this item)	. 7	
8a b	If the plan provides pension benefits, enter the applicable pension feature  If the plan provides welfare benefits, enter the applicable welfare feature c  4A 4B 4D 4E 4F 4Q				
	Plan funding arrangement (check all that apply)  (1)	(1) (2) (3) (4)	efit arrangement (check all the Insurance Code section 412(e)(3) Trust  General assets of the s	insurance cont	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are	e attached, and, w	here indicated, enter the num	ber attached. (	See instructions)
а	Pension Schedules (1) R (Retirement Plan Information)	b General (1)	Schedules  H (Financial Inform	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	I (Financial Inform  X 3 A (Insurance Inform  C (Service Provide	rmation)	Plan)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	<b>D</b> (DFE/Participate	ing Plan Inform	ation)

(6)

**G** (Financial Transaction Schedules)

**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

2013

This Form is Open to Public

Pension Benefit Guaranty Co	orporation		s are required to provide to DERISA section 103(a)(2)		on		Inspection		
For calendar plan year 20	13 or fiscal pla	an year beginning 01/01/201	3	and en	ding 12	/31/2013			
A Name of plan C.W. ROBERTS CONTRA		B Three plan			501				
C Plan sponsor's name a		ne 2a of Form 5500		<b>D</b> Emplo 59-168	-	cation Number	(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	rrier								
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a				ontract year		
(5) 2.11	code	identification number		policy or contract year		From	<b>(g)</b> To		
47-0098400	61301	010-030063	206		01/01/20	)13	12/31/2013		
2 Insurance fee and come descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in		
(a) Total a	amount of com	nmissions paid		<b>(b)</b> To	tal amount	of fees paid			
		5611					0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).					
ALLEN MOONEY & BAR			er, or other person to who B N CALHOUN ST LLAHASSEE, FL 32301	m commissi	ons or fees	s were paid			
	T	_		id			I		
(b) Amount of sales ar commissions pai		(c) Amount	ees and other commissio	(d) Purpose		(e) Organization code			
5611		(5)		(0)			3		
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons 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) Organization code		

Schedule A (Form 5500)	2013	Page <b>2 -</b> 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
(4)	and and address of the agent, stone	.,	
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / tinodit	(a) 1 dipose	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(O) / tinodin	(a) 1 diposes	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
	_		
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / unoun	(4)	3345
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
		Fees and other commissions paid	() 0
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(1)	(2)	
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	, ,	, , ,	

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Р	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated as a	a unit for purposes of
		this report.			· ·	
		rent value of plan's interest under this contract in the general account at year				
_		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	<b>L</b>	Describera a cid to contra			Ch.	
	b	Premiums paid to carrier.			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.		•	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan. o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other		ŭ		
		(3) U guaranteed investment				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		.,	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			7d	<u> </u>
		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>)</b>				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )				
					1	

Page <b>4</b>	
nployer(s) or members of erience-rated as a unit. W is a unit for purposes of th	here contracts cover inc
<b>c</b> ☐ Vision	d∏⊥ife

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	irposes if such contracts a	are experienc	ce-rated as a unit. Who	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у <b>д</b>	Supplemental unemp	oloyment	$oldsymbol{h}$ Prescription drug	
	i [	Stop loss (large deductible)	j HMO contract	k [	PPO contract		I Indemnity contrac	:t
	m	Other (specify)						
9	Expe	erience-rated contracts:						
	a ˈ⊣	Premiums: (1) Amount received		9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid	l	` '			1	
		(3) Increase (decrease) in unearned premium res		` '			1	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention	_	_		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 I	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	I in line <b>9c(2)</b>	.)	9e		
10		nexperience-rated contracts:						
		Total premiums or subscription charges paid to c				10a		112214
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
	Sp	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	

Schedule A (Form 5500) 2013

**Welfare Benefit Contract Information** 

Part III

**<sup>12</sup>** If the answer to line 11 is "Yes," specify the information not provided.

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

2013

This Form is Open to Public

, , , , , , , , , , , , , , , , , , , ,			ERISA section 103(a)(2).		ion		Inspection	
For calendar plan year 20	13 or fiscal plan	n year beginning 01/01/2013		and en	ding 12	/31/2013		
A Name of plan C.W. ROBERTS CONTRA	ACTING, INC F	LEXIBLE BENEFITS PLAN		B Three	e-digit number (PN	N) <b>•</b>	501	
C Plan sponsor's name a		e 2a of Form 5500		<b>D</b> Employ 59-168	-	ation Numbe	r (EIN)	
		ing Insurance Contract Individual contracts grouped as						
1 Coverage Information:	te defledate A.	marviadai contracto grouped as	a dilicili i arta il arta ili c	an be repe	orted of a si	rigic ocricad	o A.	
(a) Name of insurance ca	rrier							
AFLAC								
ALLAO	( ) ) ) ) )	( ) 0	(e) Approximate nu	mber of		Policy or	contract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f)	From	<b>(g)</b> To	
58-0663085	60380	D0793	18	0	01/01/20	13	12/31/2013	
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 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							
		26312					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all p	ersons).				
	(a) Name a	nd address of the agent, broker		n commissi	ions or fees	were paid		
VARIOUS OTHERS			IOUS AMA CITY, FL 32405					
(b) Amount of sales a	nd hase	Fe	es and other commission	s paid				
commissions pa		(c) Amount	(d) Purpose			(e) Organization code		
	8210						3	
	(a) Name a	nd address of the agent, broker	or other person to whon	n commissi	ions or fees	were paid		
STEVEN FALATCO	(4) 114	213	_ANDS END			noro para		
CADIZ, KY 42211								
(b) Amount of sales ar	nd base	Fe	es and other commission					
commissions pa	id	(c) Amount	(	d) Purpose	9		(e) Organization code	
	4780						3	

	broker, or other person to whom commissions or fees were pa	id
	·	iiu
	B18 N CALHOUN ST FALLAHASSEE, FL 32301	
	7.12.17.10022,12.02001	
	Fees and other commissions paid	(e) Organization
` '	(d) Purpose	code 3
		iid
	Fees and other commissions paid	(a) Organization
(c) Amount	(d) Purpose	(e) Organization code
2432		3
(a) Name and address of the agent	broker or other person to whom commissions or fees were pa	id
3	3857 SCOTT CHURCH RD	
N.	WANTANNA, FL 32440	
	Fees and other commissions paid	(e) Organization
	(d) Purpose	code 3
004		3
		iid
5 F	5728 TAMARACK DR PACE, FL 32571	
	Face and other commissions paid	
(c) Amount		(e) Organization code
		3
(a) Name and address of the agent	hreker, er ether person to whom commissions or foce were no	id.
1	137 CANDLEWOOD CIRCLE	ilu
	Fees and other commissions paid	(e) Organization
340 (c) Amount	(a) Purpose	code 3
		_
	(c) Amount  (a) Name and address of the agent,  (b) Amount  (c) Amount  (a) Name and address of the agent,  (b) Amount  (c) Amount	Fees and other commissions paid  (c) Amount  (d) Purpose  (a) Name and address of the agent, broker, or other person to whom commissions or fees were particles agent, broker, or other person to whom commissions paid  (c) Amount  (d) Purpose  Fees and other commissions paid  (d) Purpose  (e) Amount  (f) Purpose  Fees and other commissions paid  (g) Amount  (h) Purpose  (h) Purpose

0 - 11- 1 - 1	/F	FF00	0040
Schedule A	(Form	5500	2013 (

Page **2** - 2

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

TJM BENEFITS PO BOX 18552 PANAMA CITY, FL 32406				
<b>(b)</b> Amount of sales and base	/ \	Fees and other commissions paid	(e) Organization	
commissions paid 1186	(c) Amount	(d) Purpose	code 3	
1100			3	
(a) Na	me and address of the agent, brok	er, or other person to whom commissions or fees were pai	d	
VICTORIA J LENCE	11 H.	ARVARD CIRCLE AMA CITY, FL 32405		
424		Fees and other commissions paid	() 0	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
1132	, ,	, , ,	3	
<b>(a)</b> Na	me and address of the agent, brok	er, or other person to whom commissions or fees were pai	d	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
<b>(a)</b> Na	me and address of the agent, brok	er, or other person to whom commissions or fees were pai	d	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
<b>(a)</b> Na	me and address of the agent, brok	er, or other person to whom commissions or fees were pai	d	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

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Р	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated as a	a unit for purposes of
		this report.			· ·	
		rent value of plan's interest under this contract in the general account at year				
_		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	<b>L</b>	Describera a cid to contra			Ch.	
	b	Premiums paid to carrier.			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.		•	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan. o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other		ŭ		
		(3) U guaranteed investment				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		.,	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			7d	<u> </u>
		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>)</b>				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )				
					1	

Page <b>4</b>	

	Schedule A (Form 5500) 2013		Pa	ge <b>4</b>			
Part	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 sar urposes if such contracts are	experienc	e-rated as a unit. Wh	ere contracts		
<b>8</b> Be	enefit and contract type (check all applicable boxes)						
а	Health (other than dental or vision)	<b>b</b> Dental	CX	Vision	c	Life insurance	
е	Temporary disability (accident and sickness)	f  Long-term disability	_	Supplemental unem	ployment <b>h</b>	n Prescription dru	ıg
i	Stop loss (large deductible)	j  HMO contract	k	PPO contract		I  Indemnity contr	act
n	Other (specify) CANCER	- Ц				<u></u>	
	cane (openity)						
<b>9</b> Ex	perience-rated contracts:						
а	Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpai	d	9a(2)				
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		
k	Benefit charges (1) Claims paid		9b(1)				
	(2) Increase (decrease) in claim reserves		9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		
	(4) Claims charged				9b(4)		
C	Remainder of premium: (1) Retention charges (	on an accrual basis)					
	(A) Commissions		c(1)(A)				
	(B) Administrative service or other fees		c(1)(B)				
	(C) Other specific acquisition costs		c(1)(C)				
	(D) Other expenses		c(1)(D)				
	(E) Taxes		c(1)(E)				
	(F) Charges for risks or other contingencies.		c(1)(F)				
	(G) Other retention charges	9	c(1)(G)		T		
	(H) Total retention		<u></u>		9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These	e amounts were 📗 paid in ca	ash, or 📗 o	credited.)	9c(2)		
C	Status of policyholder reserves at end of year: (	) Amount held to provide be	nefits after	retirement	9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
e	Dividends or retroactive rate refunds due. (Do r	ot include amount entered in	line <b>9c(2)</b>	.)	9e		
10 1	Nonexperience-rated contracts:						
а	Total premiums or subscription charges paid to	carrier			10a		187368
k	· · · · · · · · · · · · · · · · · · ·				4.01		
	retention of the contract or policy, other than rep	orted in Part I, line 2 above,	report amo	ount	10b		

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

Specify nature of costs >

**<sup>12</sup>** If the answer to line 11 is "Yes," specify the information not provided.

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

2013

This Form is Open to Public

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				Inspection			
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013	3	and en	ding 12/	31/2013	
A Name of plan C.W. ROBERTS CONTRA	ACTING, INC I	FLEXIBLE BENEFITS PLAN			e-digit number (PN	l) <b>&gt;</b>	501
C Plan sponsor's name a		ne 2a of Form 5500		<b>D</b> Emplo	•	ation Numbe	r (EIN)
on a separat		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
HCC LIFE INSURANCE	COMPANY						
	(c) NAIC	(d) Contract or	(e) Approximate no	umber of		Policy or	contract year
<b>(b)</b> EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
35-1817054	92711	HCL30184	29	52	01/01/201	13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, I	brokers, and	other persons in
(a) Total amount of commissions paid				<b>(b)</b> To	otal amount o	of fees paid	
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(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	ad boos	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	(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 commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500)	2013	Page <b>2 -</b> 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
(4)	and and address of the agent, stone	.,	
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / tinodit	(a) 1 dipose	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(O) / tinodin	(a) 1 diposes	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
	_		
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / unoun	(4)	3345
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
		Fees and other commissions paid	() 0
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(1)	(2)	
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	, ,	, , ,	

_		
മര	$\Delta$	
ıay		•

Р	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated as a	a unit for purposes of
		this report.			· ·	
		rent value of plan's interest under this contract in the general account at year				
_		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	<b>L</b>	Describera a cid to contra			Ch.	
	b	Premiums paid to carrier.			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.		•	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan. o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other		ŭ		
		(3) U guaranteed investment				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		.,	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			7d	<u> </u>
		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>)</b>				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )				
					1	

Schedule A (Form 5500) 2013		Page <b>4</b>	
Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting potential than the entire group of such individual contracts of	roup of employees of the same urposes if such contracts are e	xperience-rated as a unit. Where contra	
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision	<b>d</b> Life insurance
emporary disability (accident and sickness)	f Long-term disability	<b>g</b> Supplemental unemployment	<b>h</b> Prescription drug
top loss (large deductible)	j HMO contract	k ☐ PPO contract	I Indemnity contract

i	X Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
m	Other (specify)	_		-		_	
	erience-rated contracts:						
а	Premiums: (1) Amount received						
	(2) Increase (decrease) in amount due but unpai	d	9a(2)				
	(3) Increase (decrease) in unearned premium res	serve	. 9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		
b	Benefit charges (1) Claims paid		. 9b(1)				
	(2) Increase (decrease) in claim reserves		. 9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		
	(4) Claims charged				9b(4)		
С	Remainder of premium: (1) Retention charges (	on an accrual basis)					
	(A) Commissions		9c(1)(A)				
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)				
	(E) Taxes		9c(1)(E)				
	(F) Charges for risks or other contingencies.		9c(1)(F)				
	(G) Other retention charges		9c(1)(G)				
	(H) Total retention				9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These	e amounts were paid ir	n cash, or	credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (1	1) Amount held to provide	benefits after	retirement	9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
е	Dividends or retroactive rate refunds due. (Do n	not include amount entere	d in line 9c(2)	.)	9e		
<b>0</b> N	onexperience-rated contracts:			•			
а	Total premiums or subscription charges paid to	carrier			10a	2309	948
b	If the carrier, service, or other organization incur	• •		•	10b		

Part IV	Provision of Information			
<b>11</b> Did tl	ne insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

8 Benefit and contract type (check all applicable boxes)

**e** ☐ Temporary disability (accident and sickness)

**a** Health (other than dental or vision)

Specify nature of costs

Part III

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

# **SCHEDULE C** (Form 5500)

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

#### **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

2013

This Form is Open to Public Inspection.

For calendar plan year 2013 or fiscal plan year beginning 01/01/2013	and ending 12/31/2013
A Name of plan C.W. ROBERTS CONTRACTING, INC FLEXIBLE BENEFITS PLAN	B Three-digit plan number (PN)
C Plan sponsor's name as shown on line 2a of Form 5500 C.W. ROBERTS CONTRACTING, INC	D Employer Identification Number (EIN) 59-1683951
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the informa or more in total compensation (i.e., money or anything else of monetary value) in conr plan during the plan year. If a person received <b>only</b> eligible indirect compensation for answer line 1 but are not required to include that person when completing the remaind	nection with services rendered to the plan or the person's position with the which the plan received the required disclosures, you are required to der of this Part.
<ul> <li>1 Information on Persons Receiving Only Eligible Indirect Compe</li> <li>a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder indirect compensation for which the plan received the required disclosures (see instructions).</li> <li>b If you answered line 1a "Yes," enter the name and EIN or address of each person process.</li> </ul>	er of this Part because they received only eligible ctions for definitions and conditions)
received only eligible indirect compensation. Complete as many entries as needed (so	• •
(b) Enter name and EIN or address of person who provided y	/ou disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	you disclosure on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect compensation

Schedule C (Fo	orm 5500) 2013	Page <b>2-</b> 1
(	(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(	<b>b)</b> Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(	<b>b)</b> Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided y	you disclosures on eligible indirect compensation
	E) Enter hame and Env of address of person who provided	you disclosures on eligible mailed compensation
(	<b>b)</b> Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
	<b>b)</b> Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
	h) Fatar ages and FIN or address of access who are sided	
	<b>b)</b> Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(	<b>(b)</b> Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation

Page <b>3 -</b> 1
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
		(	a) Enter name and EIN or	address (see instructions)		
BLUE CRO	OSS AND BLUE SHIEL	`	450 RIVE	RCHASE PKWY EAST HAM, AL 35244		
63-0103830	0					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	247057	Yes No 🛚	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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

-	2	
	-	- 2

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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	(d) 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	(g) Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of
	person known to be a party-in-interest	enter -0	other than plan or plan sponsor)	plan received the required disclosures?	eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

### Part I Service Provider Information (continued)

Turt Correct Horizon (Communica)		
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 incomprovider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	anagement, broker, or recordkeepin direct compensation and (b) each s	ng services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e 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 e the service provider's eligibility the indirect compensation.

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

Page	6-
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Pa	rt III	Termination Information on Accountants and Enrolled Actuaries (see insecomplete as many entries as needed)	structions)
а	Name:	(complete as many entires as needed)	<b>b</b> EIN:
C	Positio		D LIN.
d	Addres		e Telephone:
u	Addres	5.	e Telepriorie.
Ev	planation	<u>_</u>	
ᅜ	piariatioi	•	
			L
а	Name:		<b>b</b> EIN:
C	Positio		
d	Addres	S:	<b>e</b> Telephone:
Ex	olanatior		
а	Name:		<b>b</b> EIN:
С	Positio	n:	
d	Addres	s:	<b>e</b> Telephone:
Ex	olanatior		
а	Name:		<b>b</b> EIN:
С	Positio	n:	
d	Addres		e Telephone:
			·
Ex	olanation	:	
а	Name:		b EIN:
C	Positio	)·	w =03.
d	Addres		e Telephone:
u	Addres	s.	тетернопе.
	olonotic:	<u>_</u>	
⊏X	planatior		

# Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

2013

This Form is Open to Public Inspection

Pai	t I Annual Repo	rt Identification In	ıformatio	n					
F	or calendar plan year 2013	or fiscal plan year begir	nning (	1/01/2013	and end	ding	12/31/2	013	
Ат	his return/report is for:	a multiemployer p X a single-employer				7.0	employer plan; or cify)		
Вт	his return/report is:	the first return/rep					urn/report; n year return/repo	ort (less t	than 12 months)
C If	the plan is a collectively-ba	argained plan, check he	re						▶
D C	heck box if filing under:	Form 5558;			X aut	tomatic e	extension;	the	DFVC program;
D	+ III Dania Dian In	special extension	(enter desci	ription)					
Par		formation - enter all	requested ir	nformation					
	Name of plan  I • ROBERTS CON	mpacmina in	ī			1b	Three-digit		E 0.1
	XIBLE BENEFIT		IC				plan number (PN		501
	20 AGA (900AG). I					1c	Effective date of 01/01/20		
	Plan sponsor's name and addre			loyer, if for a single-emplo	yer plan)	2b	Employer Identif 59-16839	ication N 51	Number (EIN)
C.W	. ROBERTS CON	TRACTING, IN	IC				Sponsor's teleph -385-506		mber
337	2 CAPITAL CIR	CLE NE				2d	Business code (s 237310	see instr	ructions)
337	LAHASSEE 2 CAPITAL CIR	CLE NE	32308						
	LAHASSEE		32308						
Under p	on: A penalty for the late of enalties of perjury and other penaltic lectronic version of this return/report	es set forth in the instructions, I	declare that I ha	ive examined this return/report					
SIGN	Mr. Com	Cahner	7/30	/// ALAN I					
	Signature of plan admir	listrator	Date /	Enter name	e of individ	ual signii	ng as plan admini	strator	
SIGN									
	Signature of employer/p	olan sponsor	Date	Enter name	of individ	ual signii	ng as employer o	plan sp	onsor
SIGN									
	Signature of DFE		Date	Enter name			ng as DFE		
Prep	arer's name (including firm i	name, if applicable) and	l address; in	clude room or suite nur	nber. (optio	onal)	Preparer's telep (optional)	hone nu	ımber
MC	CRAIG SCARBRO		•				334-792	2-21	53
	O. BOX 6356	re-		20.2					
DO	THAN	AL 3	6302-6	356					
For Pa	aperwork Reduction Act N	lotice and OMB Contro	ol Numbers	, see the instructions	for Form 5	5500.			rm 5500 (2013) 130118

318401 07-17-13

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:  3 Sponsor's name  5 Total number of participants at the beginning of the plan year  6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  8 Active participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  8 Active participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  8 Active participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  9 Cother retired or separated participants receiving benefits  9 Cother retired or separated participants entitled to future benefits  9 Cother retired or separated participants whith account balances as of the end of the plan year (only defined contribution plans complete this item).  9 Total Add lines 6a and 6e  9 Number of participants with account balances as of the end of the plan year with accrued benefits that were less than 100% vested  10 Mumber of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested  11 Ein plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  12 If the plan provides velfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  13 If the plan provides velfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  13 If the plan provides velfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  14 A B 4D 4E 4F 4Q  15 Code section 412(e)(3) insurance contracts  16 Insurance  17 Insurance  18 Insurance  19 Plan benefit arrangement (check all that apply)  10	32	administrator's name and address X Same as Plan Sponsor Name X Same as Plan Sponsor Address 3b Adminis				rotor's CIN		
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(3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information)								
Information) - signed by the plan actuary (6) G (Financial Transaction Schedules)		Information) - signed by the plan actuary	(6) G	(Financial Tran	sactio	n Schedules)		