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

Pensio	in Benefit Guaranty Corporation					Inspection	
Part I	Annual Report Identif	fication Information					
For cale	ndar plan year 2013 or fiscal pla			and ending 12/31/	2013		
A This	return/report is for:	a multiemployer plan;	a multip	le-employer plan; or			
		x a single-employer plan;	a DFE (specify)			
B This	return/report is:	the first return/report;	the final	return/report;			
		an amended return/report;	☐ a short i	olan year return/report (less t	han 12 mo	onths).	
C If the	plan is a collectively-bargained	plan, check here		• • •			
D Chec	k box if filing under:	X Form 5558;	automat	ic extension;	the	e DFVC program;	
		special extension (enter des	scription)				
Part	I Basic Plan Informa	ation—enter all requested informa	ation				
	ne of plan	IC EMPLOYEE DENEET DLAN			1b	Three-digit plan number (PN) ▶	501
TAROP	MARIMACEUTICALS U.S.A., IN	IC. EMPLOYEE BENEFIT PLAN			1c	Effective date of pla	an
						01/01/2002	
	sponsor's name and address; i	include room or suite number (emp	ployer, if for a single	-employer plan)	2b	Employer Identifica Number (EIN) 11-2072868	tion
	, , , , , , , , , , , , , , , , , , , ,				2c	2c Sponsor's telephone number	
3 SKYLI	NE DRIVE	3 SKYLIN	E DRIVE		0-1	914-345-9001	
HAWTH	ORNE, NY 10532		PRNE, NY 10532		2d Business code (see instructions) 424210		
Caution	: A penalty for the late or inco	omplete filing of this return/repor	rt will be assessed	unless reasonable cause i	s establis	shed.	
		nalties set forth in the instructions, lethe electronic version of this return					
SIGN HERE	Filed with authorized/valid elec	tronic signature.	10/14/2014	MICHELE VISOSKY			
TILKE	Signature of plan administra	ator	Date	Enter name of individual s	igning as	plan administrator	
SIGN							
HERE	Signature of employer/plan	sponsor	Date	Enter name of individual s	igning as	employer or plan sp	onsor
SIGN							
HERE	Signature of DFE		Date	Enter name of individual s	igning as	DFE	
Preparer	's name (including firm name, if	f applicable) and address; include r	room or suite numbe		reparer's toptional)	telephone number	

	Form 5500 (2013)		Pag	ge 2				
3a	Plan administrator's name and address Same as Plan Sponsor Name	Same	as Pla	n Spc	nsor Addı	ess	3b Admi	nistrator's EIN
							3c Admi	nistrator's telephone
							numl	•
4	If the name and/or EIN of the plan sponsor has changed since the last retu	rn/renor	t filed fo	or this	nlan ent	er the name	4b EIN	
•	EIN and the plan number from the last return/report:	питеры	t mea it)	pian, cin	or the name,	10 2	
а	Sponsor's name						4c PN	
5	Total number of participants at the beginning of the plan year						5	196
6	Number of participants as of the end of the plan year (welfare plans complete)	ete only	lines 6	a, 6b,	6c, and 6	d).	-	
а	Active participants						6a	192
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	192
е	Deceased participants whose beneficiaries are receiving or are entitled to	rocoivo l	oonofite				6e	
f	Total. Add lines 6d and 6e.						6f	192
g	Number of participants with account balances as of the end of the plan year						6g	
	complete this item)						09	
h	Number of participants that terminated employment during the plan year w less than 100% vested						6h	
7	Enter the total number of employers obligated to contribute to the plan (onl						. 7	
8a	If the plan provides pension benefits, enter the applicable pension feature	codes fr	om the	List o	f Plan Cha	aracteristics Cod	des in the in	structions:
b	If the plan provides welfare benefits, enter the applicable welfare feature of 4A 4B 4D 4E 4F 4H 4L	odes fro	m the L	ist of	Plan Char	acteristics Code	es in the ins	tructions:
	474 40 40 41 41 41 41							
9a	Plan funding arrangement (check all that apply)	9b		enefit	_	ent (check all th	nat apply)	
	(1) X Insurance (2) Code section 412(a)(2) insurance contracts		(1)	X	Insurar) incurance	aantraata
	(2) Code section 412(e)(3) insurance contracts (3) Trust		(2) (3)	Н	Trust	ection 412(e)(3)) irisurance	contracts
	(4) General assets of the sponsor		(4)	H		l assets of the s	sponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are	attache		where			•	d. (See instructions)
а	Pension Schedules	h	Gener	al Sc	hedules			
u	(1) R (Retirement Plan Information)	2		ع. د د □		(Financial lafe	matia=\	
			(1)	Ц		(Financial Infor	,	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Ц		(Financial Infor		nall Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary		(3)	X		(Insurance Info	,	
			(4)	Ц		(Service Provid		,
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		(5)	Ц		(DFE/Participa	_	
	Information) - signed by the plan actuary		(6)		G	(Financial Tran	saction Sch	nedules)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to El	RISA section 103(a)(2).			
For calendar plan year 20	13 or fiscal plai	n year beginning 01/01/2013	and e	nding 12/3	31/2013	
A Name of plan TARO PHARMACEUTICA	LS U.S.A., INC	C. EMPLOYEE BENEFIT PLAN		ee-digit n number (PN) •	501
C Plan sponsor's name a TARO PHARMACEUTICA		e 2a of Form 5500		oyer Identifica 72868	ation Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca						
CIGNA HEALTH AND LIF	E INSURANC	E COMPANY AND AFFILIATES				
ALA FINI	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	(g) To
59-1031071	57369	3332502	192	01/01/201	3	12/31/2013
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	I commissions paid. List in line 3	the agents, b	orokers, and of	ther persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid					
		97047				58277
3 Persons receiving com	missions and fo	ees. (Complete as many entries a	as needed to report all persons).			
		and address of the agent, broker, o		sions or fees v	were paid	
LAMOTTE, NICHOLAS		SUITE	LANCASTER AVENUE 210 NOVA, PA 19085			
(1) A		Fees	and other commissions paid			
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpos	se		(e) Organization code
·	97047		NERAL AGENT PAYMENTS			3
	(a) Nama a	and address of the agent broker	or other nersen to whom commis	oiono or food	wara naid	
HEALTHY BUSINESS GR		and address of the agent, broker, agent, broker, agent, broker, agent, broker,	Y STREET, PO BOX 1346	sions or rees	were paid	
TEACHT BOOKEGO OF	(OOI , LLO		IARBOR, ŃY 11963			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pai		(c) Amount	(d) Purpos	se		(e) Organization code
	0	58277 GE	NERAL AGENT PAYMENTS			3

Schedule A (Form 5500)	2013	Page 2 - 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, profit	.,	
		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) / timodine	(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)	
(a) 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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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page	4

Pá	art II	I Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same grainformation may be combined for reporting protection the entire group of such individual contracts of the entire group of the entire group of such individual contracts of the entire group of th	urposes if such contracts	are experienc	ce-rated as a unit. Wh	nere contrac	. ,	s,
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	CX	Vision		d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disability	_	Supplemental unem	ployment	h Prescription drug	
	ı İ	Stop loss (large deductible)	j HMO contract	, J_ k□	1	. ,	I Ndemnity contract	
	' L		I I IIVIO COITITACI	ν_	11 O contract		I Muchility Contract	
	m	Other (specify)						
9	Evne	erience-rated contracts:						
•		Premiums: (1) Amount received		9a(1)				
	٠.	(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res		· · · · ·				
		(4) Earned ((1) + (2) - (3))		` ` ` `		9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)		, , ,		
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(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 2 (1)(1)		
		(H) Total retention	_			9c(1)(H)		
	_	(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1						
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
4.0	<u>е</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	.)	. 9e		_
10	_	nexperience-rated contracts:				100	0474	707
	a	Total premiums or subscription charges paid to o				. 10a	3171	/6/
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than report				. 10b		
	Sp	ecify nature of costs		•			•	
		•						

Part	: IV	Provision of Information			
11	Did the	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.

Insurance companies are required to provide the information

OMB No. 1210-0110

2013

This Form is Open to Public

			ERISA section 103(a)(2).	omation		Inspection		
For calendar plan year 20	13 or fiscal pla	an year beginning 01/01/2013	a	nd ending 12	2/31/2013			
A Name of plan TARO PHARMACEUTICA	ALS U.S.A., IN	C. EMPLOYEE BENEFIT PLAN	В	Three-digit plan number (P	N) •	501		
	C Plan sponsor's name as shown on line 2a of Form 5500 TARO PHARMACEUTICALS USA, INC. D Employer Identification Number (EIN) 11-2072868							
		ning Insurance Contract Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
CIGNA LIFE INSURANC	E CO. OF NE	W YORK						
/L\	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ontract year		
(b) EIN	code	identification number	persons covered at end policy or contract year	(1)	From	(g) To		
13-2556568	64548	SGN600372	192	01/01/20	013	12/31/2013		
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. List in l	ine 3 the agents,	brokers, and o	ther persons in		
(a) Total a	amount of con	nmissions paid		(b) Total amount	of fees paid			
		7334				0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all perso	ns).				
	(a) Name	and address of the agent, broke		nmissions or fees	s were paid			
PENTRA		2 VI	E. LANCASTER AVENUE LLANOVA CTR #210 ANOVA, PA 19085					
	T							
(b) Amount of sales ar commissions pa		(c) Amount	ees and other commissions pai	a Irpose		(e) Organization code		
σοιτιπισσιστισ μα	7334		SALES & SERVICE	110000		7		
					.,			
	(a) Name	and address of the agent, broke	r, or other person to whom com	nmissions or fees	s were paid			
(b) Amount of sales ar	nd hase	Fe	ees and other commissions pai	d				
commissions pa		(c) Amount	(d) Pu	ırpose		(e) Organization code		

Schedule A (Form 5500)	2013	Page 2 - 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) / timodine	(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)	
(a) 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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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page 4	
ployer(s) or members of the same em	р

Pa	ırt II	I Welfare Benefit Contract Informat If more than one contract covers the same gi information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experience	ce-rated as a unit. Wh	ere contrac	. ,	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	ty g	Supplemental unemp	oloyment	h Prescription drug	
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	ct
	m	Other (specify)						
9	Ехре	erience-rated contracts:						
	a I	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	db	9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	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 (c	on an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs						
		(D) Other expenses		9c(1)(D)				
		(E) Taxes						
		(F) Charges for risks or other contingencies.						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These	e amounts were paid in	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (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	ot include amount entered	d in line 9c(2)	.)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to o	carrier			10a		73340
	-	If the carrier, service, or other organization incurretention of the contract or policy, other than rep	red any specific costs in c	onnection wit	th the acquisition or	10b		
	٥.,		orted in Fart I, line 2 abov	e, report amo	Juni	100		
	ъp	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

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

v. 130118

For calendar plan year 20	For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013						
A Name of plan TARO PHARMACEUTICA	. EMPLOYEE BENEFIT PLAN	В	Three plan	e-digit number (PN)	501		
C Plan sponsor's name as shown on line 2a of Form 5500 TARO PHARMACEUTICALS USA, INC. D Employer Identification Number (EIN) 11-2072868						EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
NATIONAL BENEFIT LIF	E INSURANCE	CO.					
<i>a</i> > =	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ntract year	
(b) EIN	code	identification number	I harsons covered at and of		(f) From	(g) To	
23-1618791	61409	0161656,A	234		01/01/2013	12/31/2013	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. List in	n line 3 t	he agents, brokers, and ot	her persons in	
(a) Total a	amount of comn	nissions paid		(b) To	tal amount of fees paid		
	1332 0						
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all pers	sons).			
		nd address of the agent, broker, o	or other person to whom co				
NICHOLAS H. LAMOTTE		795 E.	LANCASTER AVENUE, 2		C		
		VILLAI	NOVA, PA 19085				
(b) Amount of sales ar	ad booo	Fees	s and other commissions pa	aid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	1332	0 INS	SURANCE AGENT OR BR	OKER		3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom co	ommissi	ons or fees were paid		
				.,			
(b) Amount of sales and base			Fees and other commissions paid (d) Purpose		,	(e) Organization code	
commissions pa	iu	(c) Amount	(a) F	uipose	;	(c) Organization code	
For Panarwark Badwatia	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form	n EEOC	Cahad	ule A (Form 5500) 2013	
	#1.1 1401111.12 21		THE DISTURBIOUS FOR COME		acheo	e # (EU) 33(KU) /U 3	

Schedule A (Form 5500)	2013	Page 2 - 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)	
(a) 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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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

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

	the entire group of such individual contracts	with each carrier may be trea	ated as a un	it for purposes of this	report.		
8	Benefit and contract type (check all applicable boxes	3)					
	a Health (other than dental or vision)	b Dental	c 🗌	Vision		d Life insurance	
	e X Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	loyment	h Prescription drug	
	i Stop loss (large deductible)	j HMO contract	k∏	PPO contract		I Indemnity contrac	t
	m ☐ Other (specify) ▶	· <u></u>					
9	Experience-rated contracts:						
	a Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpa	id	9a(2)				
	(3) Increase (decrease) in unearned premium re	eserve	9a(3)	T			
	(4) Earned ((1) + (2) - (3))				9a(4)		
	b Benefit charges (1) Claims paid		9b(1)			_	
	(2) Increase (decrease) in claim reserves	<u> </u>	9b(2)				
	(3) Incurred claims (add (1) and (2))			ħ	9b(3)		
	(4) Claims charged				9b(4)		
	c Remainder of premium: (1) Retention charges ((4)(4)			_	
	(A) Commissions		c(1)(A)			4	
	(B) Administrative service or other fees		c(1)(B)			_	
	(C) Other specific acquisition costs		c(1)(C)			_	
	(D) Other expenses		c(1)(D) c(1)(E)			_	
	(E) Taxes	-	c(1)(E)			_	
	(F) Charges for risks or other contingencies (G) Other retention charges	-	c(1)(I)			4	
	(H) Total retention				9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (Thes	_	_	l l		_	
		— •		· · · · · · · · · · · · · · · · · · ·	9c(2)		
	d Status of policyholder reserves at end of year: ('		⊢	9d(1)	+	
	(2) Claim reserves			ħ	9d(2)		
	e Dividends or retroactive rate refunds due. (Do			F F	9d(3) 9e	_	
10	Nonexperience-rated contracts:	not motate amount entered in	1 III C 30(2).	<i>,</i>	36		
. 5	Total premiums or subscription charges paid to	carrier		Γ	10a		8803
	b If the carrier, service, or other organization incu				.04		5000
	retention of the contract or policy, other than re	, .		•	10b		
	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	

Part III

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

2013

This Form is Open to Public

r ension benefit dualarity oc	riporation		s are required to provide the ERISA section 103(a)(2).	e informatio	on		Inspection
For calendar plan year 20	13 or fiscal pl	an year beginning 01/01/2013	3	and end	ling 12/	31/2013	
A Name of plan		NC. EMPLOYEE BENEFIT PLAN		B Three plan r	-digit number (PN	ı) 🕨	501
C Plan sponsor's name a				D Employ 11-2072		ation Number	(EIN)
		rning Insurance Contract Individual contracts grouped a					
(a) Name of insurance ca		W YORK					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nun persons covered at a policy or contract y	end of	(f)	Policy or o	contract year (g) To
13-2556568	65548	5GE600151	192		01/01/201	13	12/31/2013
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. Lis	t in line 3 tl	he agents, I	brokers, and o	other persons in
(a) Total a	amount of cor	nmissions paid		(b) Tot	tal amount o	of fees paid	
		5052					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all pe	ersons).			
		and address of the agent, broke			ons or fees	were paid	
PENTRA		2 V	E. LANCASTER AVENUE ILLANOVA CENTER LANOVA, PA 19085				
(h) Amount of colon or	nd book	F	ees and other commissions	paid			
(b) Amount of sales ar commissions pa		(c) Amount		l) Purpose			(e) Organization code
	5052	0					7
	(a) Name	and address of the agent, broke	or other person to whom	commission	one or fees	were paid	
	(a) Name	and address of the agent, broke	or, or other person to whom	COMMISSIO	5113 01 1003	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commissions	paid			
commissions pa		(c) Amount	(c	l) Purpose			(e) Organization code

Schedule A (Form 5500)	2013	Page 2 - 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) / timodine	(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
	_		
		Face and other commissions haid	
	(c) Amount		
	(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 naid	() 0
(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 (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 (f) Amount of sales and base commissions paid (g) Organization code (h) Amount of sales and base commissions paid (g) Organization code (h) Amount of sales and base commissions paid (g) Organization code			
	(1)	(2)	
(a) 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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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Schedule A (Form 5500) 2013		Page 4	
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 of	oup of employees of the same urposes if such contracts are	experience-rated as a unit. Where contra	. ,
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	b Dental	c Vision	d Life insurance
emporary disability (accident and sickness)	f K Long-term disability	g Supplemental unemployment	h Prescription drug
top loss (large deductible)	j HMO contract	k ☐ PPO contract	I Indemnity contract
Other (specify)	_	_	_

•	e [Temporary disability (accident and sickness) f	Long-term disabilit	у д	Supplemental unemp	loyment I	Prescription drug	
i	iΓ	Stop loss (large deductible)	HMO contract	k	PPO contract		Indemnity contract	
	m	Other (specify)	_		1		ь .	
•	L	_ canor (openity) /						
) E	хрє	rience-rated contracts:						
á	a I	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium reserve		9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	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 amo	unts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amo	ount 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 not inc	lude amount entered	I in line 9c(2)	.)	9e		
0	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier	r			10a		50520
	b	If the carrier, service, or other organization incurred ar retention of the contract or policy, other than reported				10b		

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

Specify nature of costs

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision)

Part III

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

2013

This Form is Open to Public

Pension Benefit Guaranty Co	orporation	Insurance companie pursuant to	s are required to provido c ERISA section 103(a)		ion		Inspection
For calendar plan year 20	13 or fiscal pl	an year beginning 01/01/201	3	and en	iding 12	2/31/2013	
A Name of plan TARO PHARMACEUTICA	ALS U.S.A., IN	NC. EMPLOYEE BENEFIT PLAN			e-digit number (P	N) •	501
C Plan sponsor's name a TARO PHARMACEUTICA				D Emplo		cation Numb	er (EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		W YORK					
(I) FINI	(c) NAIC	(d) Contract or	(e) Approximate			Policy o	r contract year
(b) EIN	code	identification number	persons covered policy or contr		(f)	From	(g) To
13-2556568	64548	SYK600111		192	01/01/20)13	12/31/2013
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	total commissions paid.	List in line 3	the agents,	brokers, and	d other persons in
(a) Total a	amount of cor	nmissions paid		(b) To	otal amount	of fees paid	
		15338					0
3 Persons receiving com	missions and	fees. (Complete as many entric	es as needed to report :	all persons)			
T dischie receiving cent		and address of the agent, broke			ions or fees	were naid	
PENTRA	(u) riamo	795 2 V	5 E. LANCASTER AVEN ILLANOVA CTR #10 LANOVA, PA 19085		10110 01 1000	word pand	
(b) Amount of sales ar	nd hase	F	ees and other commiss	ions paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	1534	0	SALES & SERVICE				7
	(a) Name	and address of the agent, broke	er, or other person to when	nom commiss	ions or fees	s were paid	
	<u> </u>		,				
(b) Amount of sales ar	nd base	Ę	ees and other commiss	ions paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500)	2013	Page 2 - 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, profit	.,	
		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) / timodine	(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
	_		
		Face and other commissions haid	
	(c) Amount		
	(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 naid	() 0
(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 (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 (f) Amount of sales and base commissions paid (g) Organization code (h) Amount of sales and base commissions paid (g) Organization code (h) Amount of sales and base commissions paid (g) Organization code			
	(1)	(2)	
(a) 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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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

schedule A (Form 5500) 2013		Pa	ge 4		
Welfare Benefit Contract Informal If more than one contract covers the same ginformation may be combined for reporting the entire group of such individual contracts	group of employees of the sal purposes if such contracts are	e experienc	e-rated as a unit. Where co	ontracts cover individual empl	
and contract type (check all applicable boxes)				
ealth (other than dental or vision)	b Dental	С	Vision	d Life insurance	
emporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemploym	nent h Prescription drug	J
top loss (large deductible)	j HMO contract	k	PPO contract	I Indemnity contract	ct
ther (specify) ACCIDENTAL DEATH	- <u>-</u>	_	•		
ce-rated contracts:	_				
niums: (1) Amount received		9a(1)			
ncrease (decrease) in amount due but unpa	id	9a(2)			
ncrease (decrease) in unearned premium re	serve	9a(3)			
Earned ((1) + (2) - (3))			9	a(4)	
nefit charges (1) Claims paid		9b(1)			
ncrease (decrease) in claim reserves		9b(2)			
ncurred claims (add (1) and (2))			91	b(3)	
Claims charged			91	b(4)	
mainder of premium: (1) Retention charges (on an accrual basis)				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees		9c(1)(B)			
• •	<u> </u>	(4)(0)			

a Health (other than dental or vision) **b** Dental Temporary disability (accident and sickness) Long-term disabili Stop loss (large deductible) j HMO contract m X Other (specify) ▶ACCIDENTAL DEATH Experience-rated contracts: a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid...... (3) Increase (decrease) in unearned premium reserve (4) Earned ((1) + (2) - (3))..... Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves...... (3) Incurred claims (add (1) and (2))..... (4) Claims charged Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees..... 9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies..... (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 benefits after retirement 9d(1) (2) Claim reserves 9d(2) 9d(3) (3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

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

8 Benefit and contract type (check all applicable boxes)

Part III

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

(Rev. August 2012)

Department of the Treasury Internal Revenue Service

Part I Identification

Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions. ▶ Information about Form 5558 and its instructions is at www.irs.gov/form5558 OMB No. 1545-0212

File With IRS Only

Α	Name of filer, plan administrator, or plan sponsor (see instructions)	В	Filer's	s identi	fying number	(see instructio	ns)	
	TARO PHARMCEUTICALS U.S.A., INC.	Employer identification number (EII						
	Number, street, and room or suite no. (if a P.O. box, see instructions)	1	11-2072868					
	3 SKYLINE DRIVE		Social security number (SSN) (9 digits XXX-XX-XXXX)					
	City or town, state, and ZIP code	1	00010	1 3CCU11	ty namber (55)	(a digits XXX-	·^^-^^^	
	HAWTHORNE, NY 10532							
С	Dionnes	Plan Plan year ending—			na—			
	Plan name		number		MM DD		YYYY	
		1		-		···		
	TARO PHARMACEUTICALS U.S.A., INC. EMPLOYEE BENEFIT PLAN	5	0	1	12	31	2013	
Pai	Extension of Time To File Form 5500 Series, and/or Form 89	955-8	SSA				-	
1	Check this box if you are requesting an extension of time on line 2 to file the in Part 1, C above.	e first	Form :	5500 s	series return/	report for the	plan listed	
2	I request an extension of time until 1 0 /1 5 /2 0 1 4 to file Form Note. A signature IS NOT required if you are requesting an extension to file Form	5500 m 55	series 00 seri	(see ir es.	nstructions).			
3	I request an extension of time until/ to file Form a Note. A signature IS NOT required if you are requesting an extension to file Form	8955- m 89	-SSA (8 55-SSA	see ins A.	structions).			
	The application is automatically approved to the date shown on line 2 and/or the normal due date of Form 5500 series, and/or Form 8955-SSA for which and/or line 3 (above) is not later than the 15th day of the third month after the normal date.	this e	xtensi	on is r	(a) the Form requested, a	5558 is filed and (b) the d	on or before ate on line 2	
Par	Extension of Time To File Form 5330 (see instructions)							
4 a	I request an extension of time until/ to file Form 5 You may be approved for up to a 6 month extension to file Form 5330, after the Enter the Code section(s) imposing the tax	norm	nal due	date	of Form 533	0.		
b	Enter the payment amount attached				▶	b		
с 5	For excise taxes under section 4980 or 4980F of the Code, enter the reversion/a State in detail why you need the extension:	amend	dment	date .	>			
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					***************************************		*******	
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Under p	penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on t	his for	m are tri	ie, corr	ect, and comp	lete, and that is	m authorized	
to bieb	are this application.					,		
Signat	2/07 24/10/01	do	14					
	Vice President, Tax Coursel Cat. No. 12005T					Form 5558	(Rev. 8-2012)	