# 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**

## Part I Annual Report Identification Information

For calendar plan year 2013 or fiscal plan year beginning 06/01/2013 and ending 05/31/2014

**A** This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-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 plan year return/report (less than 12 months).

**C** If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

**D** Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

## Part II Basic Plan Information—enter all requested information

**1a** Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

**1b** Three-digit plan number (PN) ▶ 501

**1c** Effective date of plan 06/01/2001

**2a** Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)

NORCAL RENTAL GROUP, LLC
CRESCO EQUIPMENT RENTALS

318 STEALTH COURT
LIVERMORE, CA 94551

318 STEALTH COURT
LIVERMORE, CA 94551

**2b** Employer Identification Number (EIN)
94-3263537

**2c** Sponsor's telephone number
925-961-0130

**2d** Business code (see instructions)
532400

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

| | | | |
|---|---|---|---|
| **SIGN HERE** | Filed with authorized/valid electronic signature. | 01/29/2015 | ELISE REEDER |
| | **Signature of plan administrator** | Date | Enter name of individual signing as plan administrator |
| **SIGN HERE** | Filed with authorized/valid electronic signature. | 01/29/2015 | ELISE REEDER |
| | **Signature of employer/plan sponsor** | Date | Enter name of individual signing as employer or plan sponsor |
| **SIGN HERE** | | | |
| | **Signature of DFE** | Date | Enter name of individual signing as DFE |

Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional)

Preparer's telephone number (optional)

**3a** Plan administrator's name and address ☐ Same as Plan Sponsor Name ☐ Same as Plan Sponsor Address

NORCAL RENTAL GROUP, LLC

318 STEALTH COURT
LIVERMORE, CA 94551

**3b** Administrator's EIN
94-3263537

**3c** Administrator's telephone number
925-961-0130

**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:

**a** Sponsor's name

**4b** EIN

**4c** PN

| | | | |
|---|---|---|---|
| **5** | Total number of participants at the beginning of the plan year | **5** | 177 |
| **6** | Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**). | | |
| **a** | Active participants | **6a** | 193 |
| **b** | Retired or separated participants receiving benefits | **6b** | |
| **c** | Other retired or separated participants entitled to future benefits | **6c** | |
| **d** | Subtotal. Add lines **6a**, **6b**, and **6c** | **6d** | 193 |
| **e** | Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | **6e** | |
| **f** | Total. Add lines **6d** and **6e**. | **6f** | 193 |
| **g** | Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | **6g** | |
| **h** | Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested | **6h** | |
| **7** | Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | **7** | |

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4H

**9a** Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

**9b** Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

**a Pension Schedules**

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

**b General Schedules**

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 6 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

**2013**

**This Form is Open to Public Inspection**

For calendar plan year 2013 or fiscal plan year beginning 07/01/2013 and ending 06/30/2014

**A** Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORCAL RENTAL GROUP, LLC

**D** Employer Identification Number (EIN)
94-3263537

**Part I** **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier

KAISER FOUNDATION HEALTH PLAN

| **(b)** EIN | **(c)** NAIC code | **(d)** Contract or identification number | **(e)** Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | **(f)** From | **(g)** To |
| 94-1340523 | 0 | 35768 | 194 | 07/01/2013 | 06/30/2014 |

**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 |
|---|---|
| 20271 | |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

NFP CA INSURANCE SERVICES INC
3470 MT DIABLO BOULEVARD
SUITE A100
LAFAYETTE, CA 94549

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | **(e)** Organization code |
| 20271 | | | |

**(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 | Fees and other 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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

## Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|---|---|---|---|
| **4** | Current value of plan's interest under this contract in the general account at year end | **4** | |
| **5** | Current value of plan's interest under this contract in separate accounts at year end | **5** | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| **b** | Premiums paid to carrier | **6b** | |
| **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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | **6d** | |

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| **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)** | |
| **d** | Total of balance and additions (add lines **7b** and **7c(6)**). | | | **7d** | |
| **e** | 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**) | | | **7f** | |

## Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [X] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

| | | | | |
|---|---|---|---|---|
| **9** Experience-rated contracts: | | | | |
| **a** 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) | |
| **c** 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 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) | |
| (3) Other reserves | | | 9d(3) | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | 9e | |
| **10** Nonexperience-rated contracts: | | | | |
| **a** Total premiums or subscription charges paid to carrier | | | 10a | 955174 |
| **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | | 10b | |

Specify nature of costs ▶

## Part IV Provision of Information

**11** Did the 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. ▶

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

**2013**

**This Form is Open to Public Inspection**

For calendar plan year 2013 or fiscal plan year beginning 06/01/2013 and ending 05/31/2014

**A** Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORCAL RENTAL GROUP, LLC

**D** Employer Identification Number (EIN)
94-3263537

**Part I** **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier

PRINCIPAL LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | (f) From | (g) To |
| 42-0127290 | 61271 | 1027557 | 494 | 06/01/2013 | 05/31/2014 |

**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 |
|---|---|
| 6212 | 2942 |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

NFP INSURANCE SERVICES
1250 S CAPITAL OF TX HWY
BLDG 2
AUSTIN, TX 78746

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | 169 | BONUS | 3 |

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

NFP CA INSURANCE SERVICES INC
3470 MT DIABLO BOULEVARD
SUITE A100
LAFAYETTE, CA 94549

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| 6212 | 2773 | BONUS | 3 |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

## Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|---|---|---|---|
| **4** | Current value of plan's interest under this contract in the general account at year end | **4** | |
| **5** | Current value of plan's interest under this contract in separate accounts at year end | **5** | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| **b** | Premiums paid to carrier | **6b** | |
| **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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | **6d** | |

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| **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)** | |
| **d** | Total of balance and additions (add lines **7b** and **7c(6)**). | | | **7d** | |
| **e** | 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**) | | | **7f** | |

## Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

| | | | |
|---|---|---|---|
| **a** [ ] Health (other than dental or vision) | **b** [X] Dental | **c** [ ] Vision | **d** [ ] Life insurance |
| **e** [ ] Temporary disability (accident and sickness) | **f** [ ] Long-term disability | **g** [ ] Supplemental unemployment | **h** [ ] Prescription drug |
| **i** [ ] Stop loss (large deductible) | **j** [ ] HMO contract | **k** [X] PPO contract | **l** [X] Indemnity contract |
| **m** [ ] Other (specify) ▶ | | | |

| | | | | |
|---|---|---|---|---|
| **9** Experience-rated contracts: | | | | |
| **a** 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)** | |
| **c** 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 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)** | |
| (3) Other reserves | | | **9d(3)** | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | **9e** | |
| **10** Nonexperience-rated contracts: | | | | |
| **a** Total premiums or subscription charges paid to carrier | | | **10a** | 166595 |
| **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | | **10b** | |

Specify nature of costs ▶

## Part IV Provision of Information

**11** Did the 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. ▶

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

**2013**

**This Form is Open to Public Inspection**

For calendar plan year 2013 or fiscal plan year beginning 06/01/2013 and ending 05/31/2014

**A** Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORCAL RENTAL GROUP, LLC

**D** Employer Identification Number (EIN)
94-3263537

## Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier

ANTHEM BLUE CROSS OF CALIFORNIA

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | (f) From | (g) To |
| 95-3760980 | 93303 | 166301 | 66 | 06/01/2013 | 05/31/2014 |

**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 |
|---|---|
| 37385 | |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

NFP CA INSURANCE SERVICES
3470 MT. DIABLO BOULEVARD
SUITE A100
LAFAYETTE, CA 94549

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| 37385 | | | 3 |

**(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 | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

## Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|---|---|---|---|
| **4** | Current value of plan's interest under this contract in the general account at year end | **4** | |
| **5** | Current value of plan's interest under this contract in separate accounts at year end | **5** | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| **b** | Premiums paid to carrier | **6b** | |
| **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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | **6d** | |

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| **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)** | |
| **d** | Total of balance and additions (add lines **7b** and **7c(6)**). | | | **7d** | |
| **e** | 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**) | | | **7f** | |

## Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [X] HMO contract
- **k** [X] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

| | | | | |
|---|---|---|---|---|
| **9** Experience-rated contracts: | | | | |
| **a** 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)** | |
| **c** 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 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)** | |
| (3) Other reserves | | | **9d(3)** | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | **9e** | |
| **10** Nonexperience-rated contracts: | | | | |
| **a** Total premiums or subscription charges paid to carrier | | | **10a** | 692786 |
| **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | | **10b** | |

Specify nature of costs ▶

## Part IV Provision of Information

**11** Did the 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. ▶

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

**2013**

**This Form is Open to Public Inspection**

For calendar plan year 2013 or fiscal plan year beginning 06/01/2013 and ending 05/31/2014

**A** Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORCAL RENTAL GROUP, LLC

**D** Employer Identification Number (EIN)
94-3263537

**Part I** **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

| **(b)** EIN | **(c)** NAIC code | **(d)** Contract or identification number | **(e)** Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | **(f)** From | **(g)** To |
| 23-1503749 | 65498 | SOK601201 | 194 | 06/01/2013 | 05/31/2014 |

**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 |
|---|---|
| 33 | |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

NFP CA INSURANCE SERVICES INC.
3470 MT. DIABLO BOULEVARD
SUITE A100
LAFAYETTE, CA 94549

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | **(e)** Organization code |
| 33 | | | 3 |

**(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 | Fees and other 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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

## Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|---|---|---|---|
| **4** | Current value of plan's interest under this contract in the general account at year end | **4** | |
| **5** | Current value of plan's interest under this contract in separate accounts at year end | **5** | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| **b** | Premiums paid to carrier | **6b** | |
| **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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | **6d** | |

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| **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)** | |
| **d** | Total of balance and additions (add lines **7b** and **7c(6)**). | | | **7d** | |
| **e** | 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**) | | | **7f** | |

## Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ ACCIDENTAL DEATH

| | | | | |
|---|---|---|---|---|
| **9** Experience-rated contracts: | | | | |
| **a** 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)** | |
| **c** 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 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)** | |
| (3) Other reserves | | | **9d(3)** | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | **9e** | |
| **10** Nonexperience-rated contracts: | | | | |
| **a** Total premiums or subscription charges paid to carrier | | | **10a** | 668 |
| **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | | **10b** | |

Specify nature of costs ▶

## Part IV Provision of Information

**11** Did the 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. ▶

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

**2013**

**This Form is Open to Public Inspection**

For calendar plan year 2013 or fiscal plan year beginning 06/01/2013 and ending 05/31/2014

**A** Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORCAL RENTAL GROUP, LLC

**D** Employer Identification Number (EIN)
94-3263537

## Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier

LIFE INSURANCE COMPANY OF AMERICA

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | (f) From | (g) To |
| 23-1503749 | 65498 | SGD601921 | 194 | 06/01/2013 | 05/31/2014 |

**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 |
|---|---|
| 883 | |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

NFP CA INSURANCE SERVICES
3470 MT. DIABLO BOULEVARD
SUITE A100
LAFAYETTE, CA 94549

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | |
|---|---|---|---|
| | (c) Amount | (d) Purpose | (e) Organization code |
| 883 | | | 3 |

**(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 | Fees and other 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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

## Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|---|---|---|---|
| **4** | Current value of plan's interest under this contract in the general account at year end | **4** | |
| **5** | Current value of plan's interest under this contract in separate accounts at year end | **5** | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| **b** | Premiums paid to carrier | **6b** | |
| **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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | **6d** | |

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| **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)** | |
| **d** | Total of balance and additions (add lines **7b** and **7c(6)**). | | | **7d** | |
| **e** | 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**) | | | **7f** | |

## Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

**a** [ ] Health (other than dental or vision) **b** [ ] Dental **c** [ ] Vision **d** [ ] Life insurance
**e** [ ] Temporary disability (accident and sickness) **f** [X] Long-term disability **g** [ ] Supplemental unemployment **h** [ ] Prescription drug
**i** [ ] Stop loss (large deductible) **j** [ ] HMO contract **k** [ ] PPO contract **l** [ ] Indemnity contract
**m** [ ] Other (specify) ▶

| | | | | |
|---|---|---|---|---|
| **9** Experience-rated contracts: | | | | |
| **a** 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)** | |
| **c** 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 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)** | |
| (3) Other reserves | | | **9d(3)** | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | **9e** | |
| **10** Nonexperience-rated contracts: | | | | |
| **a** Total premiums or subscription charges paid to carrier | | | **10a** | 17665 |
| **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | | **10b** | |

Specify nature of costs ▶

## Part IV Provision of Information

**11** Did the 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. ▶

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

**2013**

**This Form is Open to Public Inspection**

For calendar plan year 2013 or fiscal plan year beginning 06/01/2013 and ending 05/31/2014

**A** Name of plan
NORCAL RENTAL GROUP, LLC HEALTH AND WELFARE PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORCAL RENTAL GROUP, LLC

**D** Employer Identification Number (EIN)
94-3263537

**Part I** **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

| **(b)** EIN | **(c)** NAIC code | **(d)** Contract or identification number | **(e)** Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | **(f)** From | **(g)** To |
| 23-1503749 | 65498 | SGM602006 | 194 | 06/01/2013 | 05/31/2014 |

**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 |
|---|---|
| 907 | |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

NFP CA INSURNACE SERVICES
3470 MT. DIABLO BOULEVARD
SUITE A100
LAFAYETTE, CA 94549

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| 907 | | | 3 |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(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 | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

## Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|---|---|---|---|
| **4** | Current value of plan's interest under this contract in the general account at year end | **4** | |
| **5** | Current value of plan's interest under this contract in separate accounts at year end | **5** | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| **b** | Premiums paid to carrier | **6b** | |
| **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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | **6d** | |

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| **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)** | |
| **d** | Total of balance and additions (add lines **7b** and **7c(6)**). | | | **7d** | |
| **e** | 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**) | | | **7f** | |

## Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ SUPPLEMENTAL LIFE AND AD&D

| | | | | |
|---|---|---|---|---|
| **9** Experience-rated contracts: | | | | |
| **a** 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)** | |
| **c** 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 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)** | |
| (3) Other reserves | | | **9d(3)** | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | **9e** | |
| **10** Nonexperience-rated contracts: | | | | |
| **a** Total premiums or subscription charges paid to carrier | | | **10a** | 18142 |
| **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | | **10b** | |

Specify nature of costs ▶

## Part IV Provision of Information

**11** Did the 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. ▶

Form **5558**
(Rev. August 2012)

Department of the Treasury
Internal Revenue Service

# 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**

## Part I Identification

**A** Name of filer, plan administrator, or plan sponsor (see instructions)

Number, street, and room or suite no. (If a P.O. box, see instructions)

City or town, state, and ZIP code

**B** **Filer's identifying number (see instructions)**

Employer identification number (EIN) (9 digits XX-XXXXXXX)

Social security number (SSN) (9 digits XXX-XX-XXXX)

| **C** Plan name | Plan number | Plan year ending — MM | DD | YYYY |
|---|---|---|---|---|
| | | | | |

## Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

**1** ☐ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above.

**2** I request an extension of time until ____/____/____ to file Form 5500 series (see instructions).
**Note.** A signature IS NOT required if you are requesting an extension to file Form 5500 series.

**3** I request an extension of time until ____/____/____ to file Form 8955-SSA (see instructions).
**Note.** A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application **is automatically approved** to the date shown on line 2 and/or line 3 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

## Part III Extension of Time To File Form 5330 *(see instructions)*

**4** I request an extension of time until ____/____/____ to file Form 5330.
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.

**a** Enter the Code section(s) imposing the tax . . . . . ▶ **a**

**b** Enter the payment amount attached . . . . . ▶ **b**

**c** For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . ▶ **c**

**5** **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

**Signature ▶** **Date ▶**

# General Instructions

*Section references are to the Internal Revenue Code unless otherwise noted.*

## What's New

The June 2011 version of Form 5558 required a signature for extensions of time to file Form 8955-SSA. A signature is no longer required for an extension to file Form 8955-SSA. As under the June 2011 version of Form 5558, a signature is also not required to extend the time to file Form 5500 series; however, a signature is still required to extend the time to file Form 5330.

The June 2011 version of the Form 5558 provided space for the names of three plans; as a result a single Form 5558 could be used to extend the time to file returns for three plans. The Form 5558 now limits the extension to a single plan. Applications for extensions of other plans must be submitted on additional Forms 5558. As under current rules, lists of other plans should not be attached to a Form 5558. Lists attached to Form 5558 will not be processed. Only the plan listed on Form 5558 will be processed.

A new checkbox has been added for recently adopted plans that are requesting an extension of time to file a Form 5500 series return/report where a Form 5500 series return/report is being filed for that plan for the first time.

## Future Developments

For the latest information about developments related to Form 5558 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/form5558*.

## Purpose of Form

Use Form 5558 to apply for a one-time extension of time to file the Form 5500 series (Form 5500, Annual Return/Report of Employee Benefit Plan; Form 5500-SF, Short Form Annual Return/Report of Small Employee Benefit Plan; Form 5500-EZ, Annual Return of One-Participant (Owners and Their Spouses) Retirement Plan); Form 8955-SSA, Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits; or Form 5330, Return of Excise Taxes Related to Employee Benefit Plans.




*To avoid processing delays, the most recent version of this Form 5558 should always be used. For example, this Form 5558 (Rev. August 2012) should be used instead of the June 2011 version or any other prior version. To determine the most recent version of this Form, go to* IRS.gov/retirement.

## Where To File

File Form 5558 with the Department of the Treasury, Internal Revenue Service Center, Ogden, UT 84201-0045.

**Private delivery services.** You can use certain private delivery services designated by the IRS to meet the "timely mailing treated as timely filing/paying" rule for tax returns and payments. If you use a private delivery service designated by the IRS (rather than the U.S. Postal Service) to send your return, the postmark date generally is the date the private delivery service records in its database or marks on the mailing label. The private delivery service can tell you how to get written proof of this date.

The following are designated private delivery services:

- DHL Express (DHL): DHL Same Day Service.
- Federal Express (FedEx): FedEx Priority Overnight, FedEx Standard Overnight, FedEx 2 Day, FedEx International Priority, and FedEx International First.
- United Parcel Service (UPS): UPS Next Day Air, UPS Next Day Air Saver, UPS 2nd Day Air, UPS 2nd Day Air A.M., UPS Worldwide Express Plus, and UPS Worldwide Express.

# Specific Instructions

## Part I. Identification

### A. Name and Address

Enter your name and address in the heading if you are requesting an extension of time to file the Form 5500, Form 5500-SF, Form 5500-EZ and/or Form 8955-SSA or Form 5330.

The plan sponsor (generally, the employer for a single-employer plan) or plan administrator listed on the application should be the same as the plan sponsor or plan administrator listed on the annual return/report filed for the plan.

Include the suite, room, or other unit number after the street address. If the Post Office does not deliver mail to the street address and you have a P.O. box, show the box number instead of the street address.

If the entity's address is outside the United States or its possessions, or territories, enter in the space for city or town, state, and ZIP code, the information in the following order: city, province or state, and country. Follow the country's practice for entering the postal code. Do not abbreviate the country name.

If your mailing address has changed since you filed your last return, use Form 8822, Change of Address, to notify the IRS of the change. A new address shown on Form 5558 will not update your record.

### B. Filer's Identifying Number

**Employer identification number (EIN).** Enter the nine-digit EIN in an XX-XXXXXXX format, assigned to the employer for all applications filed for the Form 5500 series (Form 5500, Form 5500-SF, Form 5500-EZ) and/or Form 8955-SSA. Also enter the EIN for applications filed for Form 5330 (see *Social security number (SSN)* next for exceptions).

If the employer does not have an EIN, the employer must apply for one. An EIN can be applied for:

- Online by clicking the Online EIN Application link at IRS.gov. The EIN is issued immediately once the application information is validated.

**Note.** The online application process is not yet available for corporations with addresses in foreign countries.

- By telephone at 1-800-829-4933.
- By fax using the FAX-TIN numbers for your state listed in the Instructions for Form SS-4.
- Employers who do not have an EIN may apply for one by attaching a completed Form SS-4, Application for Employer Identification Number, to this form.

**Social security number (SSN).** If you made excess contributions to a section 403(b)(7)(A) custodial account or you are a disqualified person other than an employer, and you are applying for an extension of time to file Form 5330, enter your nine-digit SSN in an XXX-XX-XXXX format. Do not enter your SSN for Form 5500, Form 5500-SF, Form 5500-EZ, or Form 8955-SSA.

### C. Plan Information

Complete the plan name, plan number, and plan year ending for the plan included on this Form 5558.

## Part II. Extension of Time To File Form 5500 Series and/or Form 8955-SSA

Use Form 5558 to apply for a one-time extension of time to file the Form 5500 series (Form 5500, Form 5500-SF, Form 5500-EZ) and/or Form 8955-SSA.




*Do not include the Form 5500 series (Form 5500, Form 5500-SF, Form 5500-EZ) or the Form 8955-SSA with this form.*

***Exception:*** Form 5500, Form 5500-SF, Form 5500-EZ, and Form 8955-SSA filers are automatically granted extensions of time to file until the extended due date of the federal income tax return of the employer (and are not required to file Form 5558) if both of the following conditions are met: (1) the plan year and the employer's tax year are the same; and (2) the employer has been granted an extension of time to file its federal income tax return to a date later than the normal due date for filing the Form 5500, Form 5500-SF, Form 5500-EZ, or Form 8955-SSA. An extension granted under this exception cannot be extended further by filing a Form 5558 after the normal due date of the Form 5500, Form 5500-SF, Form 5500-EZ, or Form 8955-SSA.

An extension of time to file a Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA does not operate as an extension of time to file the PBGC (Pension Benefit Guaranty Corporation) Form 1, Annual Premium Payment.

**How to file.** A separate Form 5558 must be used for each plan for which an extension is requested. For example, if an employer maintains a defined benefit plan and a profit-sharing plan, a separate Form 5558 must be filed for each plan. A single Form 5558 may, however, be used to extend the time to file a plan's Form 5500 series return/report and its Form 8955-SSA.

Lists of other plans should not be attached to a Form 5558. Only the plan listed on Form 5558 will be processed. Lists attached to the Form 5558 will not be processed.

**When to file.** To request an extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA, file Form 5558 on or before the return/report's normal due date. The normal due date is the date the Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA would otherwise be due, without extension.

Applications for extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA that are filed on or before the return/report's normal due date on a properly completed Form 5558 will be automatically approved to the date that is no later than the 15th day of the third month after the return/report's normal due date.

**Note.** If the filing date falls on a Saturday, Sunday, or a legal holiday, the return may be filed on the next day that is not a Saturday, Sunday, or a legal holiday.

Approved copies of Form 5558 requesting an extension to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA will not be returned to the filer from the IRS.

**Line 1.** Check this box if the extension of time being requested on line 2 is for the first Form 5500 series return/report filed for the plan. This box should not be checked if the plan previously filed a Form 5500 series return/report at any time for any year.

**Line 2.** Enter on line 2 the due date for which you are requesting to file Form 5500, Form 5500-SF, or Form 5500-EZ. This date should not be later than the 15th day of the third month after the normal due date of the return/report.

When using Form 5558 to request an extension of time to file Form 5500, Form 5500-SF, or Form 5500-EZ, plan sponsors or plan administrators are not required to sign the form. If Form 5558 is timely filed and complete, you will be granted an extension not later than the 15th day of the third month after the return/report's normal due date to file Form 5500, Form 5500-SF, or Form 5500-EZ.

**Line 3.** Enter on line 3 the due date for which you are requesting to file Form 8955-SSA. This date should not be later than the 15th day of the third month after the normal due date of the return.

When using Form 5558 to request an extension of time to file Form 8955-SSA, plan sponsors or plan administrators are not required to sign the form. If Form 5558 is timely filed and complete, you will be granted an extension not later than the 15th day of the third month after the return's normal due date to file Form 8955-SSA.

## Part III. Extension of Time To File Form 5330

File one Form 5558 to request an extension of time to file Form 5330 for excise taxes with the same filing due date. For specific information on excise tax due dates, see the Instructions for Form 5330.

CAUTION *An extension of time to file does not extend the time to pay the tax due. Any tax due must be paid with this application for an extension of time to file Form 5330. Additionally, interest is charged on taxes not paid by the due date even if an extension of time to file is granted.*

**Note.** The IRS will no longer return stamped copies of the Form 5558 to filers who request an extension of time to file a Form 5330. Instead you will receive a computer generated notice to inform you if your extension is approved or denied. Because of this change, we ask you to attach a photocopy of this notice to your Form 5330.

**When to file.** To request an extension of time to file Form 5330, file Form 5558 in sufficient time for the IRS to consider and act on it before the return's normal due date.

The normal due date is the date the Form 5330 would otherwise be due, without extension.

**Line 4.** On line 4, enter the requested due date. If your application for extension of time to file Form 5330 is approved, you may be granted an extension of up to 6 months after the normal due date of Form 5330.

**Line 4a.** Indicate the section(s) for the excise tax for which you are requesting an extension.

**Line 4b.** Enter the amount of tax estimated to be due with Form 5330 and attach your payment to this form.

Make your check or money order payable to the "United States Treasury." Do not send cash. On all checks or money orders, write your name, filer's identifying number (EIN or SSN), plan number, Form 5330 section number, and the tax year to which the payment applies.

If you changed your mailing address after you filed your last return, use Form 8822 to notify the IRS of the change. You can get Form 8822 by calling 1-800-829-3676 or you can access the IRS website at IRS.gov 24 hours a day, 7 days a week.

**Line 5.** The IRS will grant a reasonable extension of time (not to exceed 6 months) for filing Form 5330 if you file a timely application showing that you are unable to file Form 5330 because of circumstances beyond your control. Clearly describe these circumstances. Generally, an application will be considered on the basis of your own efforts to fulfill this filing responsibility, rather than the convenience of anyone providing help in preparing the return. However, consideration will be given to any circumstances that prevent your practitioner, for reasons beyond his or her control, from filing the return by the normal due date, and to circumstances in which you are unable to get needed professional help in spite of timely efforts to do so.

CAUTION *If we grant you an extension of time to file Form 5330 and later find that the statements made on this form are false or misleading, the extension will be null and void. A late filing penalty associated with the form for which you filed this extension will be charged.*

## Signature

If you are filing Form 5558 for an extension to file Form 5330, the Form 5558 must be signed. The person who signs this form may be an employer, a plan sponsor, a plan administrator, a disqualified person required to file Form 5330, an attorney or certified public accountant qualified to practice before the IRS, a person enrolled to practice before the IRS, or a person holding a power of attorney.

If you are filing Form 5558 for an extension to file Form 5500 series return/report or Form 8955-SSA, a signature is not required.

## Privacy Act and Paperwork Reduction Act Notice

We ask for the information on this form to carry out the Internal Revenue laws of the United States and the Employee Retirement Income Security Act of 1974 (ERISA). We need it to determine if you are entitled to an extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA, or Form 5330. You are not required to request an extension; however, if you want an extension, section 6081 requires you to provide the information. Section 6109 requires you to provide your identification number. Failure to provide this information may delay or prevent processing your request; providing false information may subject you to penalties.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential as required by section 6103.

However, section 6103 allows or requires the Internal Revenue Service to disclose this information to others. We may disclose to the Department of Justice for civil or criminal litigation, to the Department of Labor and the Pension Benefit Guaranty Corporation for the administration of ERISA, and to cities, states, the District of Columbia, and U.S. commonwealths or possessions to carry out their tax laws. We may also disclose the information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time: 24 minutes.

If you have comments concerning the accuracy of this time estimate or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:M:S, 1111 Constitution Ave., NW, IR-6526, Washington, DC 20224. Do not send the tax form to this address. Instead, see *Where To File*.

KAISER PERMANENTE®

INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

**Part I: Information Concerning Insurance Coverage, Fees, and Commissions**

Name of Insurance Carrier: Kaiser Foundation Health Plan Inc
Plan Sponsor's Name: NORCAL RENTAL GROUP, LLC DBA CRESCO EQUI

017555 2/2

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: CA
Insurance Carrier: Kaiser Foundation Health Plan Inc
Insurance Carrier Employer Identification Number: 94-1340523
Insurance Carrier NAIC Code: 00000
Plan Sponsor Contract or Identification Number: 35768
Approximate number of persons covered at end of policy contract year: 194
Contract Year from 07/2013 - 06/2014

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: $20,271.15
Total Amount of Fees Paid: $0.00

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

NFP CA Insurance Services, Inc.
3470 MT DIABLO BLVD STE A100
LAFAYETTE, CA 94549-3958

Amount of sales and base commissions paid to NFP CA Insurance Services, Inc.:
$20,271.15
Fees and other compensation paid to NFP CA Insurance Services, Inc.:
$0.00

Bonus Amount: $0.00
Bonus Purpose:
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation:

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00

Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

---

**Part II: Investment and Annuity Contract Information**

Kaiser Foundation Health Plan Inc is not offering you an investment or annuity contract.

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**Part III: Welfare Benefit Contract Information**

Benefit and Contract Type: HMO Contract

Premium received by Kaiser Foundation Health Plan Inc during your plan's contract year: $955,173.98

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**Part IV: Provision of Information**

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.

Barbara Ishikawa

Barbara Ishikawa
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
08/08/2014

**BROKER COPY**

Principal Life Insurance Company
Des Moines, IA 50392
(515) 247-5111

June 24, 2014

NORCAL RENTAL GROUP LLC
ATTN ELISE REEDER
318 STEALTH COURT
LIVERMORE CA 94550

NFP CA INSURANCE SERVICES INC
3470 MT DIABLO BLVD
STE A100
LAFAYETTE CA 94549-3958

**Account No. 1027557**

The Schedule A (Form 5500) worksheet will be available online through the Employer Web link. If you do not have Employer Web access, please call the Corporate Contact Services Center at 1-800-621-6280 to assist you with enrolling in the Employer Web Service.

Your group policy anniversary was June 1, 2014. Most insured welfare benefit plans of 100 or more plan participants are required to file Form 5500 with the Department of Labor. The filing of the form satisfies a portion of ERISA reporting and disclosure requirements. In order to complete the filing, Schedule A (Form 5500) is needed. We've enclosed your Schedule A Insurance Information worksheet for the period June 1, 2013 through May 31, 2014 to assist you with the filing. Please review your plan for filing implications.

Further information on Form 5500 can be viewed at www.dol.gov/ebsa. The Department of Labor requires filings to be submitted electronically. To electronically file your Form 5500, see www.efast.dol.gov. Additional help with EFAST can be obtained by calling the EFAST help line at 1-866-GO-EFAST (1-866-463-3278). For help with Form 5500 filing questions specific to your plan, please contact your legal or tax advisor. Principal Life Insurance Company cannot give legal or tax advice.

The paid premium reported on the Schedule A worksheet (Form 5500) represents premium received and applied to your account during the period being reported.

Thank you for selecting Principal Life Insurance Company for your insurance needs. If you have questions about the enclosed information, please contact me at the number listed below.

Sincerely,

Cindi Cochran
Principal Financial Group
SBD Support Operations
Phone 1-800-986-3343 Press '1' for Directory Assistance, Ext. 57111

Enclosure

Principal Financial Group

**Principal Life Insurance Company**
Des Moines, Iowa 50392-0001 Schedule A (Form 5500)

Information needed from insurer to complete the Annual Report Schedule A Part I

Data for Period June 01, 2013 to May 31, 2014

Name of Plan NORCAL RENTAL GROUP LLC Three Digit Plan Number - -

Name of Sponsor _____ Employer ID Number -

1. Coverage

| Name of Insurance Carrier (A) | EIN (B) | NAIC Code (C) | Contract or Identification Number (D) | Approx. no. of Persons cov. At End of Policy Year (E) |
|---|---|---|---|---|
| Principal Life Insurance Company | 42-0127290 | 61271 | 1027557 | 494 |

Policy or Contract Year From (F) 06/01/2013 To (G) 05/31/2014

Combined Numbers

2. Insurance fee and commission information

| | Amount of Commissions Paid | Fees paid / Amount |
|---|---|---|
| Total | 6,212 | 2,942 |

3. Persons receiving commissions and fees

| Name & Address of Agents or Brokers to whom Commissions or Fees Paid (A) | Amount of Commissions Paid (B) | Fees Paid Amount (C) | Fees Paid Purpose (D) |
|---|---|---|---|
| NFP CA INSURANCE SERVICES INC<br>3470 MT DIABLO BLVD<br>STE A100<br>LAFAYETTE CA 94549-3958 | 6,212 | 2,773 | * Bonus |
| (E) Organizational Code: _3_ | | | |
| NFP INSURANCE SERVICES INC<br>1250 S CAPITAL OF TX HWY<br>BLDG 2<br>AUSTIN TX 78746-6464 | | 169 | * Bonus |
| (E) Organizational Code: _3_ | | | |

(E) Organizational codes.

| | | |
|---|---|---|
| 1 - Banking, Savings & Loan Assoc., Credit Union or other similar financial institution | | |
| 2 - Trust Co | 5 - Third Party Administrator | 8 - Labor Union |
| 3 - Insurance Agent or Broker | 6 - Investment Co/Mutual Fund | 9 - Foreign Entity |
| 4 - Agent or Broker other than Ins. | 7 - Investment Manager/Advisor | 0 - Other |

* This compensation amount is the amount paid. It is not the actual cost charged. This amount is an administrative expense allocated across all policies sold by Principal Life Insurance Company.

Anthem Blue Cross Blue Shield
1351 Wm. Howard Taft Rd.
Cincinnati, Ohio 45206-1721
Mail Drop: OH0401-B265

01/02/2015
Customer ID: 166301
DCN:

Attention Human Resource
Manager:
NORCAL RENTAL GROUP LLC
DBA CRESCO
318 STEALTH COURT
LIVERMORE, CA 94551

Attention Plan Administrator:

Enclosed you will find information that may assist you in the completion of your ERISA Form 5500 Schedule A and Schedule C. For those plans that file both a Schedule A and Schedule C, information necessary to complete those Schedules is combined into a single report.

The information contained in the following report is designed to assist you with your reporting obligations as outlined by the U.S. Department of Labor, the Department of the Treasury and the Pension Benefit Guaranty Corporation as outlined in 29 CFR Part 2520. This information is based on the contract period of all insurance policies and/or service agreements between you and us. You are under no obligation to use this data if you believe you have better internal information.

Other items to note:

- All information is presented on a cash basis. If the transaction occurred during your policy year it will be included even if it pertains to a prior or subsequent policy year.
- Dental benefits provided by Anthem on the DeCare billing system will be reported on a separate ERISA Form 5500 directly from DeCare.

If this document has reached you in error, please forward it and the attached information to your Plan Administrator or the person or department responsible for completing your company's tax reporting obligations.

If you have any questions, please contact your Account Manager.

Sincerely,

*William J Hammer*
*Staff VP Finance*

## Information For Completion Of ERISA 5500 Schedule A

**Name of Plan :** NORCAL RENTAL GROUP LLC DBA CRESCO
**For Period :** 06/01/2013 - 05/31/2014
**Customer ID :** 166301

## Part I Information Concerning Insurance Contract Coverage, Fees and Commissions

### 1. Coverage Information

| a. Name of carrier(s) | b. EIN | c. NAIC Code | Coverages |
|---|---|---|---|
| Blue Cross of California (G0200) | 95-3760980 | 933 0303 | Health HMO |
| Blue Cross of California (G0200) | 95-3760980 | 933 0303 | Health PPO |

* See part III for enrollment detail

### 2. and 3. Insurance Fee and Commission Information

| *Broker* | *Sales And Base Commission Paid* | *Fees Paid** |
|---|---|---|
| NFP CA INSURANCE SERVICES, INC<br>3470 MT. DIABLO BLVD. STE. A100<br>LAFAYETTE, CA 94549 | $37,385.32 | $0.00 |

** Fees include Bonus, Override and Non Monetary compensation. Purpose of these fees is incentives, education, communication and training. Use 3 for organization type code.*

*We are reporting commission payments separately from overrides, bonus payments and other compensation that may be paid to your broker or consultant. These payments (overrides, bonuses and other compensation ), if any,are reflected in the overall administrative cost structure and were not directly included in the determination of rates. These overrides, bonuses and other compensation were allocated to your coverage(s) on a pro rata basis to all policies enrolled through the broker or consultant which contribute to eligibility for the amounts awarded. Payments are reported as of the date we consider the payment paid or processed.*

## Non Experience Rated Contracts

## Part III Welfare Benefit Contract Information

| 8. Type | 8. Benefit | 10a. Premium | Approximate Enrollment (Subscribers/ Members) |
|---|---|---|---|
| a/k | Health PPO | $222,281 | 26 / 48 |
| a/j | Health HMO | $470,505 | 40 / 93 |
| b | Dental | - | |
| c | Vision | - | |
| d | Life Insurance* | - | |
| e | STD | - | |

| 8. Type | 8. Benefit | 10a. Premium | Approximate Enrollment (Subscribers/ Members) |
|---|---|---|---|
| f | LTD | - | |
| g | Supp Unemployment | - | |
| h | Prescription Drug | - | |
| j | Stop Loss | - | |
| a/l | Health Indemnity | - | |
| m | Other | - | |

** Includes AD&D, Voluntary, Supplemental and Dependent Life Premiums if applicable.*

*Note: Premium and enrollment data can vary based on retroactive adjustments that may not have been processed at time of report. Enrollment provided for employer self billed Benefit Plans is the best available number at this point in time. Life and Disability enrollment may also be unavailable in certain cases. Employer should use enrollment data as of the last month of the reporting period.*

## Schedule C

**Name of Plan :** NORCAL RENTAL GROUP LLC DBA CRESCO

**For Period :** 06/01/2013 - 05/31/2014

**Customer ID :** 166301

## Part I Service Provider Information

### 1a & b. Information on Persons Receiving Only Eligible Indirect Compensation

In early 2015, provided your plan additional disclosure or clarification of eligible indirect compensation received by itself, its affiliates and vendors utilized in connection with subrogation, recovery, network access, negotiated savings and float. To the extent your plan has access to the BlueCard network, this disclosure also provided information regarding any payments for BlueCard made to other Blue Cross and/or Blue Shield plans for network access and services.This disclosure supplements the information contained in your administrative services agreement. Any other Indirect Compensation for which disclosure was not provided is listed below.

### 2a-h. Information on Other Service Providers Receiving Direct or Indirect Compensation.

### 3a-e Service Provider Information

| Service Codes | Direct Compensation | Indirect Compensation | Sources | Sources EIN | Description |
|---|---|---|---|---|---|
| - | - | - | - | - | - |

The following footnotes are applicable only if listed above.

1 Administration fees are based on enrollment at a given point in time and may vary based on timing of enrollment adjustments. To the extent your plan has access to the Blue Card network, and depending upon the terms of your agreement, your plan may be billed and we may receive Blue Card access fees. However, system constraints currently make it impractical to separately identify and report these fees in an automated fashion and are therefore not included in the direct compensation figure herein. For additional information on the fees, if any, billed in connection with your plan, please contact your account administrator.

2 Prescription Drug Rebates and related administrative fees if applicable; are estimated for the reporting period based on a historical average of rebates received by the service provider, divided by the total number of units of all prescription drugs claims (including those drugs that may not be subject to a drug rebate program) incurred by plans or policies administered by that service provider over that period, to arrive at an average rebate for each drug claim unit. This average, times the plan's actual units for the period, results in the estimated amount of rebates received by the service provider in connection with the plan. Estimated rebates do not take into consideration any rebate revenue returned to the plan or used as an offset to administrative fees; see your administrative services agreement for additional information.

3 Therapy Management, Compliance and Persistency consist of compensation received for educational and outreach services to providers and participants to help improve outcomes. This compensation is calculated based on the total number of outreach contacts per group times the average rate per contact agreed upon by the service providers. For the reporting period these fees are from Pfizer, Inc and Merck.

4 Pharmacy Data Sales Revenue is calculated based on the total revenue received for the claims data divided by the total claims sent (mail order only) to determine an average claim rate that is multiplied by the sent claims per account to determine revenue for each account.

5 Fees may include Bonus, Override and Non Monetary compensation. Purpose of these fees is incentives, education, communication and training. We are reporting commission payments separately from overrides, bonus payments and other compensation that may be paid to your broker or consultant. These payments (overrides, bonuses and other compensation), if any, are reflected in the overall administrative cost structure and were not directly included in the determination of rates. These overrides, bonuses and other compensation were allocated to your coverage(s) on a pro rata basis to all policies enrolled through the broker or consultant which contribute to eligibility for the amounts awarded. Payments are reported as of the date we consider the payment paid or processed.

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The undersigned company (ies), hereby certify that the foregoing statement furnished pursuant to 29 C.F.R. 2520.103-5(c) is complete and accurate.



*William J Hammer*
*Staff VP Finance*
*Date: 01/02/2015*

*Note: For certain plans, self funded products are administered by more than one legal entity. In that event, indirect compensation may be aggregated to just one of those legal entities, as method used to derive those fees is determined separately from the administrative entity.*

CIGNA Group Insurance
P.O. Box 20643
Lehigh Valley, PA 18002-0643

CIGNA Group Insurance
Life · Accident · Disability

NORCAL RENTAL GROUP, LLC
FOR CLAIMS PURPOSES ONLY
318 STEALTH COURT
LIVERMORE CA 94551

**Document No.** 4647H-Y

# Annual Policy Information Report

Date Prepared: 06/20/14

| Name of Insurance Carrier<br>LIFE INSURANCE COMPANY OF NORTH AMERICA | |
|---|---|
| EIN | 23-1503749 |
| NAIC Code | 65498 |
| Contract/Policy number | SOK601201 |
| Contract/Policy Year From: | 06-01-13 |
| Contract/Policy Year To: | 06-01-14 |

| Policy Or Benefit Type |
|---|
| ACCIDENTAL DEATH |

* Approximate Number of persons covered at the end of the policy year:

* *Please refer to your census reports or billing statement for this information.*

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: $ 667.65

See reverse side for total Commissions and fees paid by Insurance Company during the policy year.

| Agent Number | Name and Address of Each Recipient of Fees and/or Commissions | Amount of Commissions Paid | Amount of Fees Paid | Purpose For Which Paid |
|---|---|---|---|---|
| 179191 | NFP CA INSURANCE SERVICES<br>3470 MT DIABLO BV # A100<br>LAFAYETTE, CA 94549 | 33.43 | .00<br>.00 | Sales & Service<br>Override |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact MISSY BANNON at 610-758-7019.

CIGNA Group Insurance
P.O. Box 20643
Lehigh Valley, PA 18002-0643

CIGNA Group Insurance
Life · Accident · Disability

NORCAL RENTAL GROUP, LLC
ATTN: ELISE REEDER
318 STEALTH COURT
LIVERMORE CA 94551

**Document No.** 4647H-Y

# Annual Policy Information Report

Date Prepared: 06/20/14

| Name of Insurance Carrier<br>LIFE INSURANCE COMPANY OF NORTH AMERICA | |
|---|---|
| EIN | 23-1503749 |
| NAIC Code | 65498 |
| Contract/Policy number | SGD601921 |
| Contract/Policy Year From: | 06-01-13 |
| Contract/Policy Year To: | 06-01-14 |

| Policy Or Benefit Type |
|---|
| LONG TERM DISABILITY |

* Approximate Number of persons covered at the end of the policy year:

* *Please refer to your census reports or billing statement for this information.*

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: $ 17,665.12

See reverse side for total Commissions and fees paid by Insurance Company during the policy year.

| Agent Number | Name and Address of Each Recipient of Fees and/or Commissions | Amount of Commissions Paid | Amount of Fees Paid | Purpose For Which Paid |
|---|---|---|---|---|
| 179191 | NFP CA INSURANCE SERVICES<br>3470 MT DIABLO BV # A100<br>LAFAYETTE, CA 94549 | 883.25 | .00<br>.00 | Sales & Service<br>Override |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact MISSY BANNON at 610-758-7019.

CIGNA Group Insurance
P.O. Box 20643
Lehigh Valley, PA 18002-0643

CIGNA Group Insurance
Life • Accident • Disability

NORCAL RENTAL GROUP, LLC
ATTN: ELISE REEDER
318 STEALTH COURT
LIVERMORE CA 94551

**Document No.** 4647H-Y

## Annual Policy Information Report

Date Prepared: 06/20/14

| Name of Insurance Carrier<br>LIFE INSURANCE COMPANY OF NORTH AMERICA | |
|---|---|
| EIN | 23-1503749 |
| NAIC Code | 65498 |
| Contract/Policy number | SGM602006 |
| Contract/Policy Year From: | 06-01-13 |
| Contract/Policy Year To: | 06-01-14 |

| Policy Or Benefit Type |
|---|
| BASIC LIFE<br>SUPP. LIFE<br>DEPENDENT LIFE<br>ACC. DEATH & DISMEMB. |

* Approximate Number of persons covered at the end of the policy year:

* *Please refer to your census reports or billing statement for this information.*

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: $ 18,142.02

See reverse side for total Commissions and fees paid by Insurance Company during the policy year.

| Agent Number | Name and Address of Each Recipient of Fees and/or Commissions | Amount of Commissions Paid | Amount of Fees Paid | Purpose For Which Paid |
|---|---|---|---|---|
| 179191 | NFP CA INSURANCE SERVICES<br>3470 MT DIABLO BV # A100<br>LAFAYETTE, CA 94549 | 907.09 | .00<br>.00 | Sales & Service<br>Override |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact MISSY BANNON at 610-758-7019.

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# Group Premium Invoice Remittance

CIGNA Group Insurance
Life • Accident • Disability

| | | | |
|---|---|---|---|
| Account Number | 0943283537-0000 | Total Premium Due | $ 3,134.79 |
| Invoice Number | 0943263537 0000 050114 14121 4 | Invoice Date | 05/01/2014 |
| | | Coverage Period | 05/01/2014 - 05/31/2014 |
| | | Due Date | 05/31/2014 |

**Name and Address Change:**

_____
_____
_____
_____

**Billing Location:**
NORCAL RENTAL GROUP, LLC
318 STEALTH COURT
LIVERMORE, CA 94551

**Remit Payment to:**
LINA
P.O. Box 13701
Philadelphia, PA 19101-3701

To remit payment offline, please print this statement landscape and mail all printed pages with your payment.
*To avoid processing delays, be sure to check your printed copy to verify that all of the information can be clearly read.*

## Invoice Detail

| Item # | Product | Current Period # of Insured Employees | Current Period $ Total Inforce Coverage | Current Period Rate / Per | Current Period Premium | Prior Period Adjustments # of Insured Employees + or - | Prior Period Adjustments $ Total Inforce Coverage + or - | Prior Period Adjustments Adjust + or - | Total Premium |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Basic LTD (ER Paid)<br>Family Code: Employee<br>Policy: SGD601921<br>Suffix: 000<br>Pay Code: 000<br>Cov Code: 808 | 194 | 838,818.56 | 0.182 / $ 100 | 1,526.65 | 0 | 0.00 | 0.00 | 1,526.65 |
| 2 | Basic Term Life<br>Family Code: Employee<br>Policy: SGM602006<br>Suffix: 000<br>Pay Code: 000<br>Cov Code: 010 | 194 | 4,841,250.00 | 0.100 / $ 1000 | 484.13 | 0 | 0.00 | 0.00 | 484.13 |
| 3 | Voluntary Term Life<br>Policy: SGM602006<br>Suffix: 000<br>Pay Code: 000<br>Cov Code: 020 | | | | | | | | |
| | Under 20 | 0 | 0.00 | 0.064 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 20-24 | 0 | 0.00 | 0.064 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 25-29 | 0 | 0.00 | 0.064 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 30-34 | 1 | 100,000.00 | 0.085 / $ 1000 | 8.50 | 0 | 0.00 | 0.00 | 8.50 |
| | 35-39 | 5 | 770,000.00 | 0.112 / $ 1000 | 86.24 | 0 | 0.00 | 0.00 | 86.24 |
| | 40-44 | 3 | 260,000.00 | 0.175 / $ 1000 | 45.50 | 0 | 0.00 | 0.00 | 45.50 |
| | 45-49 | 5 | 660,000.00 | 0.307 / $ 1000 | 202.62 | 0 | 0.00 | 0.00 | 202.62 |
| | 50-54 | 9 | 1,000,000.00 | 0.499 / $ 1000 | 499.00 | 0 | 0.00 | 0.00 | 499.00 |
| | 55-59 | 2 | 40,000.00 | 0.898 / $ 1000 | 35.92 | 0 | 0.00 | 0.00 | 35.92 |
| | 60-64 | 0 | 0.00 | 1.393 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 65-69 | 0 | 0.00 | 2.580 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 70-74 | 0 | 0.00 | 5.429 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 75-79 | 0 | 0.00 | 5.429 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 80-84 | 0 | 0.00 | 5.429 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 85-89 | 0 | 0.00 | 5.429 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 90-94 | 0 | 0.00 | 5.429 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 95-99 | 0 | 0.00 | 5.429 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | Sub-Total | 25 | 2,830,000.00 | | 877.78 | 0 | 0.00 | 0.00 | 877.78 |
| 4 | Voluntary Dependent Life<br>Policy: SGM602006 | | | | | | | | |

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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Suffix: 000<br>Pay Code: 000<br>Cov Code: 030 | | | | | | | | |
| | Under 20 | 0 | 0.00 | 0.064 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 20-24 | 0 | 0.00 | 0.064 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 25-29 | 0 | 0.00 | 0.064 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 30-34 | 1 | 30,000.00 | 0.085 / $ 1000 | 2.55 | 0 | 0.00 | 0.00 | 2.55 |
| | 35-39 | 0 | 0.00 | 0.112 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 40-44 | 2 | 40,000.00 | 0.175 / $ 1000 | 7.00 | 0 | 0.00 | 0.00 | 7.00 |
| | 45-49 | 1 | 30,000.00 | 0.307 / $ 1000 | 9.21 | 0 | 0.00 | 0.00 | 9.21 |
| | 50-54 | 1 | 30,000.00 | 0.499 / $ 1000 | 14.97 | 0 | 0.00 | 0.00 | 14.97 |
| | 55-59 | 1 | 25,000.00 | 0.898 / $ 1000 | 22.45 | 0 | 0.00 | 0.00 | 22.45 |
| | 60-64 | 1 | 15,000.00 | 1.393 / $ 1000 | 20.90 | 0 | 0.00 | 0.00 | 20.90 |
| | 65-69 | 0 | 0.00 | 2.580 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 70-74 | 0 | 0.00 | 0.000 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 75-79 | 0 | 0.00 | 0.000 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 80-84 | 0 | 0.00 | 0.000 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 85-89 | 0 | 0.00 | 0.000 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 90-94 | 0 | 0.00 | 0.000 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | 95-99 | 0 | 0.00 | 0.000 / $ 1000 | 0.00 | 0 | 0.00 | 0.00 | 0.00 |
| | **Sub-Total** | 7 | 170,000.00 | | 77.08 | 0 | 0.00 | 0.00 | 77.08 |
| 5 | **Voluntary Dependent Life**<br>Family Code: Child<br>Policy: SGM602006<br>Suffix: 000<br>Pay Code: 000<br>Cov Code: 030 | 7 | 35,000.00 | 0.210 / $ 1000 | 7.35 | 0 | 0.00 | 0.00 | 7.35 |
| 6 | **Basic AD&D**<br>Family Code: Employee<br>Policy: SGM602006<br>Suffix: 000<br>Pay Code: 000<br>Cov Code: 570 | 194 | 4,841,250.00 | 0.020 / $ 1000 | 96.83 | 0 | 0.00 | 0.00 | 96.83 |
| 7 | **Voluntary AD&D**<br>Family Code: Employee<br>Policy: SOK601201<br>Suffix: 934<br>Pay Code: 000<br>Cov Code: 560 | 10 | 1,830,000.00 | 0.029 / $ 1000 | 53.07 | 0 | 0.00 | 0.00 | 53.07 |
| 8 | **Voluntary AD&D**<br>Family Code: Spouse<br>Policy: SOK601201<br>Suffix: 934<br>Pay Code: 000<br>Cov Code: 560 | 8 | 565,000.00 | 0.019 / $ 1000 | 10.74 | 0 | 0.00 | 0.00 | 10.74 |
| 9 | **Voluntary AD&D**<br>Family Code: Child<br>Policy: SOK601201<br>Suffix: 934<br>Pay Code: 000<br>Cov Code: 560 | 8 | 40,000.00 | 0.029 / $ 1000 | 1.16 | 0 | 0.00 | 0.00 | 1.16 |
| | | | | | | | **Total Premium Due** | | 3,134.79 |