Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pensio	on Benefit Guaranty Corporation					Inspection	
Part I	Annual Report Identi						
For cale	ndar plan year 2013 or fiscal pla	an <u>year beginning</u> 07/01/2013		and ending 06/30	/2014		
A This	return/report is for:	a multiemployer plan;	a multipl	e-employer plan; or			
	•	a single-employer plan;	☐ a DFE (s	specify)			
		- a congretion proof or proof,	□ ' '	,,, <u>—</u>			
_		The first return (remain	المعالم المعالم				
B This	return/report is:	the first return/report;	<u>=</u>	return/report;			
		an amended return/report;	a short p	olan year return/report (less	than 12 m	ionths).	
C If the	plan is a collectively-bargained	plan, check here				. X	
	k box if filing under:	Form 5558;	_	c extension;		ые DFVC program;	
D Chec	k box ii iiiing under.	· 블		c extension,		le Di vo piogram,	
		special extension (enter des	, ,				
Part		ation—enter all requested informa	ation		1		ı
	ne of plan				1b	Three-digit plan	502
HANDE:	X CONSULTING AND REMEDI	ATION			4-	number (PN) ▶	
					10	Effective date of pla 07/01/2007	an
2a Blor	anapaor's name and address:	include room or suite number (emp	playor if for a single	omployor plan)	2b		tion
Za Fiai	i sponsoi s name and address,	include room or suite number (emp	pioyer, ir ior a sirigle	-employer plan)	20	Number (EIN)	itiOH
HANDE	X CONSULTING AND REMEDI	ATION				20-3908055	
TIANDL	X CONSCENING AND REMEDI	ATION			2c	Sponsor's telephon	ne
						number	.0
						321-441-9801	1
1350 OF #101	RANGE AVE	1350 ORA SUITE 10	ANGE AVE		2d	Business code (see	е
	R PARK, FL 32789		PARK, FL 32789		instructions)		
				562000			
Caution	· A nenalty for the late or inco	omplete filing of this return/repor	rt will he assesed	unless reasonable cause	is establi	shed	
		nalties set forth in the instructions,					dulas
		the electronic version of this return					
SIGN	Filed with authorized/valid elec	stronio cianoturo					
HERE							
	Signature of plan administra	ator	Date	Enter name of individual	signing as	s plan administrator	
SIGN HERE							
IILKE	Signature of employer/plan	sponsor	Date	Enter name of individual	signing as	employer or plan sp	onsor
SIGN							
HERE	Signature of DEE		Date	Enter name of individual	alanina aa	DEE	
Prenarei	Signature of DFE 's name (including firm name, if	annlicable) and address: include		Enter name of individual		telephone number	
					optional)	tolophono nambol	
2701 MAITLAND CENTER PARKWAY						407-628-3441	
	MILAND CENTER FARRWAY						
#125	ND, FL 32751						
IVIALLA	ND, I E 32/31						

	Form 5500 (2013)		Page 2	2					
3a	Plan administrator's name and address XSame as Plan Sponsor Name	Same as	Same as Plan Sponsor Address				3b Administrator's EIN		
						3c Adı	ministrator's telephone		
							mber		
4	If the name and/or EIN of the plan sponsor has changed since the last return	/report fi	led for th	nis n	olan enter the name	4b EII	N		
•	EIN and the plan number from the last return/report:	и сроп п	ica ioi tii	iio p	man, enter the name,				
а	Sponsor's name					4c PN	l .		
5	Total number of participants at the beginning of the plan year					5	161		
6	Number of participants as of the end of the plan year (welfare plans complete	e only lin	es 6a, 6 k	b, 6	c, and 6d).				
9	Active participants					. 6a	160		
a	Active participants						100		
b	Retired or separated participants receiving benefits					. 6b			
С	Other retired or separated participants entitled to future benefits					. 6c			
d	Subtotal. Add lines 6a, 6b, and 6c					. 6d	160		
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive her	nefits			. 6e			
T	Total. Add lines 6d and 6e .					. 6f			
g	Number of participants with account balances as of the end of the plan year complete this item)					. 6g			
						. 09			
h	Number of participants that terminated employment during the plan year with less than 100% vested					. 6h			
7	Enter the total number of employers obligated to contribute to the plan (only	multiemp	oloyer pla	ans	complete this item)	. 7			
8a	If the plan provides pension benefits, enter the applicable pension feature co	des from	the List	of F	Plan Characteristics Cod	les in the	instructions:		
_									
b	If the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4F 4H	les from t	the List o	of P	lan Characteristics Code	s in the i	nstructions:		
	47. 48. 48. 41. 411								
9a	Plan funding arrangement (check all that apply)			fit a	rrangement (check all th	at apply)			
	(1) Insurance (2) Code section 412(e)(3) insurance contracts	(1)	-	X	Insurance Code section 412(e)(3)	inguranc	e contracts		
	(3) Trust	(3	-		Trust	modrano	c contracts		
	(4) X General assets of the sponsor	(4	-	X	General assets of the s	ponsor			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	-1		ere	indicated, enter the num	ber attac	hed. (See instructions)		
а	Pension Schedules	b G	eneral S	Sch	edules				
	(1) R (Retirement Plan Information)	(1	١ - ١	1	H (Financial Infor	mation)			
	(O) I MD (Multi-angles on Defined Deposit Discount Cont.)		_	_	`	,	Consul Diago		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2	_	¥	I (Financial Inform		Small Plan)		
	actuary	(3	_	^	8 A (Insurance InfoC (Service Provide	,	nation)		
	(2) CP (Single Employer Defined Benefit Blan Astronial	(4 (5	_		D (DFE/Participat		,		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6	=		G (Financial Tran	-			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2013

,			ERISA section 103(a)(2).	mation	Inspection		
For calendar plan year 20	13 or fiscal pla	n year beginning 07/01/2013	an	d ending 06/30/2014			
A Name of plan HANDEX CONSULTING	AND REMEDIA	ATION		Three-digit plan number (PN)	502		
C Plan sponsor's name as shown on line 2a of Form 5500 HANDEX CONSULTING AND REMEDIATION D Employer Identification Number (EIN) 20-3908055							
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:	e Scriedule A.	marviduai contracts grouped as	s a unit in Faits ii and in can be	reported on a single Sched	Jule A.		
(a) Name of insurance ca							
LINCOLN NATIONAL LIF	E INSURANC	E COMPANY					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of		or contract year (g) To		
35-0472300	65676	10128888	policy or contract year	07/01/2013	06/30/2014		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. List in lir	ne 3 the agents, brokers, ar	nd other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
	4137 0						
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all person	s).			
		and address of the agent, broker		missions or fees were paid			
FRINGE BENEFIT PLAN	S, INC.	#100	I LEE RD) TER PARK, FL 32789				
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Pur	pose	(e) Organization code		
	4137				3		
	(a) Name a	and address of the agent, broker	r, or other person to whom com	missions or fees were paid			
				·			
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Pur	pose	(e) Organization code		

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

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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page 4	
employer(s) or members of the same en operience-rated as a unit. Where contract d as a unit for purposes of this report.	. , , ,
c Vision g Supplemental unemployment k PPO contract	d Life insurance h Prescription drug

		information may be combined for reporting putthe entire group of such individual contracts with	urposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contrac		
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	e X	Temporary disability (accident and sickness)	f Long-term disabilit	у д [Supplemental unemp	oloyment	h Prescription drug	
	i 🗏	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)	,	_	1		_ ,	
9	Expe	rience-rated contracts:						
	a P	remiums: (1) Amount received		9a(1)				
	((2) Increase (decrease) in amount due but unpaid	j	9a(2)				
	((3) Increase (decrease) in unearned premium res	serve	9a(3)				
	((4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid	-	` '				
	((2) Increase (decrease) in claim reserves		9b(2)		r		
	((3) Incurred claims (add (1) and (2))				9b(3)		
	,	(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	· · · · · · · · · · · · · · · · · · ·				_	
		(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)		ı		
		(H) Total retention	<u>.</u>			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide I	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e		
10	Non	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a		20687
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo	, ,			10b		
	Spe	ecify nature of costs						

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

Schedule A (Form 5500) 2013

Part III Welfare Benefit Contract Information

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2013

r ension benefit dualarity oc	проганоп		s are required to provide to ERISA section 103(a)(2)		ion		Inspection	
For calendar plan year 20	13 or fiscal pl	an year beginning 07/01/2013	3	and en	ding 06/	30/2014		
A Name of plan HANDEX CONSULTING	AND REMED	IATION			e-digit number (PN	l) •	502	
C Plan sponsor's name a				D Emplo 20-390	-	ation Number	(EIN)	
		rning Insurance Contract . Individual contracts grouped a						
(a) Name of insurance ca		CE						
/I-> FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year	
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To	
35-0472300	65676	10128885	16	160 0		13	06/30/2014	
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents,	brokers, and c	other persons in	
		mmissions paid		(b) To	otal amount	of fees paid		
		2962					0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
FRINGE BENEFIT PLAN		#10	1 LEE RD	n commiss	ions or fees	were paid		
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid				
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code	
	2962						3	
	(a) Name	and address of the agent, broke	er or other person to who	n commiss	ions or fees	were paid		
	(a) Name	and address of the agent, broke	n, or other person to who	ii commiss	10113 01 1003	were paid		
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code	

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

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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e		5		
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

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

10b

i	i Stop loss (large deductible)	j 📗 HMO contract 💮 k 📗 PPO contrac	t I ∐ Inde	emnity contract
ı	m X Other (specify) ▶AD& D			
Е	Experience-rated contracts:			
á	a Premiums: (1) Amount received			
	(2) Increase (decrease) in amount due but unpa	aid 9a(2)		
	(3) Increase (decrease) in unearned premium re	eserve 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. (Thes	se 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	
0	Nonexperience-rated contracts:			
		carrier	10a	14809
	h If the carrier service or other organization incu	irred any specific costs in connection with the acquisition	on or	

retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....

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

Specify nature of costs

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

Part III

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2013

,			ERISA section 103(a)(2).	lation	Inspection	
For calendar plan year 20	13 or fiscal pla	n year beginning 07/01/2013	and e	ending 06/30/2014		
A Name of plan HANDEX CONSULTING	AND REMEDIA	ATION		ree-digit an number (PN)	502	
C Plan sponsor's name as shown on line 2a of Form 5500 HANDEX CONSULTING AND REMEDIATION D Employer Identification Number (EIN) 20-3908055						
			Coverage, Fees, and Cor a unit in Parts II and III can be re			
1 Coverage Information:						
(a) Name of insurance ca	rrier					
LINCOLN NATIONAL LIF	E INSURANC	E COMPANY				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		contract year	
(2) 2	code	identification number	policy or contract year	(f) From	(g) To	
35-0472300	65676	400128887	81	07/01/2013	06/30/2014	
2 Insurance fee and come descending order of the		ation. Enter the total fees and tot	al commissions paid. List in line	3 the agents, brokers, and	other persons in	
(a) Total a	amount of com	missions paid	(b)	Total amount of fees paid		
6950						
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all persons).			
	. ,	<u> </u>	or other person to whom commit	ssions or fees were paid		
FRINGE BENEFIT PLAN	S, INC		TER PARK, FL 32789			
(b) Amount of sales ar	nd base	Fee	es and other commissions paid			
commissions pai		(c) Amount	(d) Purpose		(e) Organization code	
	6950				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 Fees and other commissions paid			(2) (2) (3)			
commissions pa	ıd	(c) Amount	(d) Purpo	OSE	(e) Organization code	

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

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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e		5		
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) curer y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

schedule A (Form 5500) 2013		Pa	ge 4	
Welfare Benefit Contract Informa	tion		<u> </u>	
If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa urposes if such contracts a	re experienc	e-rated as a unit. Where contra	
and contract type (check all applicable boxes))			
ealth (other than dental or vision)	b Dental	С	Vision	d Life insurance
emporary disability (accident and sickness)	f Long-term disability	g 🗌	Supplemental unemployment	h Prescription drug
top loss (large deductible)	j HMO contract	k 🗌	PPO contract	I Indemnity contract
ther (specify) VOLUNTARY LIFE	_	<u> </u>		_
ce-rated contracts:	_			
niums: (1) Amount received		9a(1)		
ncrease (decrease) in amount due but unpai	d	9a(2)		
ncrease (decrease) in unearned premium re-	serve	9a(3)		
Earned ((1) + (2) - (3))	<u>.</u>		9a(4)	
nefit charges (1) Claims paid		9b(1)		
ncrease (decrease) in claim reserves		9b(2)		
ncurred claims (add (1) and (2))			9b(3)	
Claims charged			9b(4)	
mainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
(C) Other enecific acquisition costs		9c(1)(C)		

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) **b** Dental Temporary disability (accident and sickness) Long-term disabili Stop loss (large deductible) HMO contract m X Other (specify) ▶VOLUNTARY LIFE Experience-rated contracts: a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid..... (3) Increase (decrease) in unearned premium reserve (4) Earned ((1) + (2) - (3))..... Benefit charges (1) Claims paid..... (2) Increase (decrease) in claim reserves...... (3) Incurred claims (add (1) and (2))..... (4) Claims charged Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees..... (C) Other specific acquisition costs (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies..... (H) Total retention..... 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)..... 9c(2)d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) 9d(3) (3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 34789 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

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

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2013

			RISA section 103(a)(2).		Inspection	
For calendar plan year 20	13 or fiscal plan	year beginning 07/01/2013	and en	iding 06/30/2014		
A Name of plan HANDEX CONSULTING	AND REMEDIA	TION		e-digit number (PN)	502	
C Plan sponsor's name a HANDEX CONSULTING			D Emplo 20-390	oyer Identification Number 08055	(EIN)	
			overage, Fees, and Comi unit in Parts II and III can be repo			
1 Coverage Information:						
(a) Name of insurance ca	rrier					
BLUE CROSS BLUE SH	IELD OF FLOR	IDA				
4) 501	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	ontract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
59-2015694	98167	B5320	138	07/01/2013	06/30/2014	
2 Insurance fee and com descending order of the		tion. Enter the total fees and total	I commissions paid. List in line 3	the agents, brokers, and o	other persons in	
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid					
		68737			0	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons).			
	· ,	<u> </u>	or other person to whom commiss	ions or fees were paid		
FRINGE BENEFIT PLAN	, INC		EE RD ER PARK, FL 32789			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose		(e) Organization code	
	57831				3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
LASSITER WARE INC PO BOX 490690 LEESBURG, FL 34749-0690						
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code	
	10906				3	
For Panerwork Reduction	on Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500.	Scho	dule A (Form 5500) 2013	

Schedule A (Form 5500)	2013	Page 2 - 1			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
(4)	and and address of the agent, profit	.,			
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(o) / tinodit	(a) 1 dipose	0000		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(O) / timodine	(a) 1 diposes	0000		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
	_				
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(o) / unoun	(4)	3345		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
		Fees and other commissions paid	() 0		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(1)	()			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of calca and har-		Fees and other commissions paid	(2) Omanination		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

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

а	X Health (other than dental or vision)	b Dental	С	Vision	d	Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	, g∏	Supplemental unemployme	nt h	Prescription drug
i	Stop loss (large deductible)	j HMO contract	k∏	PPO contract	ıĒ	Indemnity contract
n		,	Ш		L	, ,
) Ex	perience-rated contracts:	_				
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpa	id	9a(2)			
	(3) Increase (decrease) in unearned premium re	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))	<u>.</u>		9a	4)	
k	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))			9b((3)	
	(4) Claims charged			9b(4)	
C	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs	⊢	9c(1)(C)			
	(D) Other expenses	<u> </u>	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)	<u>, </u>		
	(H) Total retention			9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in	cash, or 🗌 c	redited.)9c	(2)	
C	Status of policyholder reserves at end of year: (1) Amount held to provide b	enefits after	retirement 9d	(1)	
	(2) Claim reserves			9d((2)	
	(3) Other reserves			9d((3)	
E	Dividends or retroactive rate refunds due. (Do	not include amount entered	in line 9c(2) .)90	e	
0	lonexperience-rated contracts:					
a	Total premiums or subscription charges paid to	carrier		10	а	1374740
k	If the carrier, service, or other organization incu			·	b	

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

Specify nature of costs >

8 Benefit and contract type (check all applicable boxes)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2013

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	13 or fiscal plar	year beginning 07/01/2013		and en	ding 06	/30/2014	
A Name of plan HANDEX CONSULTING	AND REMEDIA	TION		B Three plan	e-digit number (PN	N) •	502
C Plan sponsor's name as shown on line 2a of Form 5500 HANDEX CONSULTING AND REMEDIATION D Employer Identification Number 20-3908055				ation Number	(EIN)		
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:	to concado 71.	marviadar contracto grouped ac	a ant in r and in and in a	an be repe	ortou orr a or	ingic concadi	071.
(a) Name of insurance ca	arrier						
LINCOLN NATIONAL LIF		COMPANY					
LINCOLN NATIONAL LII			(e) Approximate nu	mber of		Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f)	From	(g) To
35-0472300	65676	400176162	10	1	07/01/20	13	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							
	1316						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	ersons).			
EDINOE DENESIT DI ANI		nd address of the agent, broker	, or other person to whon LEE RD	n commissi	ions or fees	were paid	
FRINGE BENEFIT PLAN	IS, INC	100					
		WIN	ΓER PARK, FL 32789				
(b) Amount of sales an commissions pa		(c) Amount	ees and other commissions paid (d) Purpose			(e) Organization code	
	1078	(e) / milearia	`) . a.poo	<u> </u>		3
LACOIED MADE INC	(a) Name a	nd address of the agent, broker	or other person to whon GOX 490690	n commissi	ions or fees	were paid	
LASSIER WARE INC			SBURG, FL 34749				
(b) Amount of sales a			es and other commission				_
commissions pa		(c) Amount	(d) Purpose	9		(e) Organization code
	238						1

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

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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) clifer y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page 4	

Schedule A	(Form	5500)	2013
OCHEUUIE A	(1 01111	3300	2013

Pa	ırt l	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts of	oup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	C 🔀	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д	Supplemental unemp	oloyment	h Prescription drug	
	i į	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)		<u> </u>	1		ь,	
9	Ехр	erience-rated contracts:						
	a	Premiums: (1) Amount received		9a(1)			7	
		(2) Increase (decrease) in amount due but unpaid	1	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	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)		r		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	, the state of the				_	
		(A) Commissions		9c(1)(A)			4	
		(B) Administrative service or other fees		9c(1)(B)			_	
		(C) Other specific acquisition costs		9c(1)(C)			_	
		(D) Other expenses	ļ ·	9c(1)(D)			_	
		(E) Taxes	⊢	9c(1)(E) 9c(1)(F)			4	
		(F) Charges for risks or other contingencies		9c(1)(G)			4	
		(G) Other retention charges(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	_	_			<u> </u>	
	d	Status of policyholder reserves at end of year: (1		<u></u>		9c(2)		
	u	(2) Claim reserves	•			9d(1) 9d(2)		
		(3) Other reserves				9d(2)		
	е	Dividends or retroactive rate refunds due. (Do no				90(3) 9e		
10	_	enexperience-rated contracts:	or morade amount entered	111 IIIIC 30(2)	.,,	30		
. •	а	Total premiums or subscription charges paid to o	arrier			10a	13	158
	b	If the carrier, service, or other organization incur				- 100		
		retention of the contract or policy, other than repo	, ·		•	10b		
	Sp	pecify nature of costs						

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

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to EF	RISA section 103(a)(2).			mapeonon	
For calendar plan year 20	13 or fiscal plan	year beginning 07/01/2013	and e	nding 0	6/30/2014		
A Name of plan HANDEX CONSULTING	AND REMEDIA	TION	B Thre	ee-digit n number (F	PN)	502	
C Plan sponsor's name as shown on line 2a of Form 5500 HANDEX CONSULTING AND REMEDIATION D Employer Identification Number (E 20-3908055)					EIN)		
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
LINCOLN NATIONAL LIF	FE INSURANCE	COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
35-0472300	65676	1D026378	57	07/01/2	013	06/30/2014	
2 Insurance fee and com descending order of the		tion. Enter the total fees and total	commissions paid. List in line 3	the agents	, brokers, and of	ther persons in	
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid						
		4396					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all persons).				
		nd address of the agent, broker, o		sions or fee	s were paid		
FRINGE BENEFIT PLAN	IS, INC	#100	ER PARK, FL 32789				
(b) Amount of sales a	nd base	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpose		(e) Organization code		
	3973					3	
	(a) Name ar	nd address of the agent, broker, o	or other person to whom commis	sions or fee	s were paid		
LASSITER WARE INC. PO BOX 490690 LEESBURG, FL 34749							
(b) Amount of sales a	nd base	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code		
	423					3	

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

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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Schedule A (Form 5500) 2013		Page 4	
Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sam surposes if such contracts are	experience-rated as a unit. Where contra	. ,
and contract type (check all applicable boxes)		
lealth (other than dental or vision)	b X Dental	c Vision	d Life insurance
emporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k ☐ PPO contract	I Indemnity contract
NH (15 -)			

	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insu	ırance
	е	Temporary disability (accident and sickness)	f Long-term disability	ty g	Supplemental unempl	oyment	h Prescrip	tion drug
	ιĬ	Stop loss (large deductible)	j HMO contract	k [PPO contract		_	ty contract
	m	Other (specify)	,				- []ee	.,
9	Ехре	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpai	d	9a(2)				
		(3) Increase (decrease) in unearned premium re-	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees					_	
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes					_	
		(F) Charges for risks or other contingencies.					_	
		(G) Other retention charges		9c(1)(G)	1			
		(H) Total retention	_	_	-	9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	e amounts were 📗 paid ir	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do r	ot include amount entered	d in line 9c(2) .	.)	9e		
10	No	nexperience-rated contracts:			-			
	а	Total premiums or subscription charges paid to	carrier			10a		43963
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b		

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

Specify nature of costs >

8 Benefit and contract type (check all applicable boxes)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)				
For calendar plan year 2013 or fiscal plan year beginning 07/01/2013 and ending 06/30/2014							
A Name of plan HANDEX CONSULTING AND REMEDIATION					e-digit number (P	N) •	502
C Plan sponsor's name a HANDEX CONSULTING				D Emplo		cation Number (EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
LINCOLN NATIONAL LIF	E INSURANCI	E COMPANY					
(I.) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
35-0472300	65676	1D026394	5	70	07/01/20	013	06/30/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents	brokers, and ot	her persons in
(a) Total a	amount of comi	missions paid		(b) To	otal amount	of fees paid	
		3046					
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).			
		and address of the agent, broke		m commiss	ions or fee	s were paid	
FRINGE BENEFIT PLAN	S, INC.	#100	I LEE RD) TER PARK, FL 32789				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa	id	(c) Amount	(d) Purpose			(e) Organization code	
2734							3
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
LASSITER WARE INC PO BOX 490690 LEESBURG, FL 34749							
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	306						3

Schedule A (Form 5500)	2013	Page 2 - 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
(4)	and and address of the agent, stone	.,				
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / tinodit	(a) 1 dipose	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(O) / tinodin	(a) 1 diposes	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
	_					
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / unoun	(4)	3345			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
		Fees and other commissions paid	() 0			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(1)	()				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page 4	
employer(s) or members of the same er xperience-rated as a unit. Where contra d as a unit for purposes of this report.	
c Vision g Supplemental unemployment k PPO contract	d ☐ Life insurance h ☐ Prescription drug l ☐ Indemnity contract

Pa	rt II	I Welfare Benefit Contract Information If more than one contract covers the same gray information may be combined for reporting pothe entire group of such individual contracts of the contract of t	oup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Who	ere contract		
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д [Supplemental unemp	oloyment	h Prescription drug	
	ιĒ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	t
	m	Other (specify)	- L		•			
9	Expe	rience-rated contracts:						
	a F	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	9a(3)		T		
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves		9b(2)		T		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	·				_	
		(A) Commissions	F	9c(1)(A)			_	
		(B) Administrative service or other fees	T T T T T T T T T T T T T T T T T T T				_	
		(C) Other specific acquisition costs		9c(1)(C)			_	
		(D) Other expenses		9c(1)(D)			4	
		(E) Taxes	•	9c(1)(E)			_	
		(F) Charges for risks or other contingencies.		9c(1)(F)			_	
		(G) Other retention charges				9c(1)(H)	_	
		(H) Total retention						
	-1	(2) Dividends or retroactive rate refunds. (These				9c(2)		
	d	Status of policyholder reserves at end of year: (1				9d(1)		
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	.)	9e		
IU		nexperience-rated contracts:				40-		00000
		Total premiums or subscription charges paid to d				10a	+	30399
		If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b		
	Sp	ecify nature of costs						

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

Schedule A (Form 5500) 2013

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2013

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).						Inspection		
For calendar plan year 2013 or fiscal plan year beginning 07/01/2013 and					ding 06	5/30/2014		
A Name of plan HANDEX CONSULTING	AND REMEDI	ATION			e-digit number (Pl	N) •	502	
	C Plan sponsor's name as shown on line 2a of Form 5500 HANDEX CONSULTING AND REMEDIATION D Employer Identification Number (EIN) 20-3908055							
	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:	o Concadio 71	. marriadar contracto grouped t	io a dilicili i alto il dila ili	oan be repe	ontou on a s	ingle concade	7.6	
(a) Name of insurance ca LINCOLN NATIONAL LIF		CE COMPANY						
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	it end of	(f)	From	ontract year (g) To	
35-0472300	65676	10128886	' '	61	07/01/20)13	06/30/2014	
2 Insurance fee and composite descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
		nmissions paid		(b) To	tal amount	of fees paid		
, ,		2981		` ,		·	0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
<u> </u>		and address of the agent, broke			ions or fees	were paid		
FRINGE BENEFIT PLAN	S, INC	100	1 LEE RD NTER PARK, FL 32789					
		F	ees and other commissio	ne naid				
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code	
·	2981	,,		. ,			3	
	(a) Name	and address of the agent, broke	ar or other person to who	m commiss	ions or fees	were paid		
	(a) Name	and address of the agent, broke	er, or other person to who	III COIIIIII33	10113 01 1003	were paid		
(b) Amount of sales ar			ees and other commissio					
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code	

Schedule A (Form 5500)	2013	Page 2 - 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
(4)	and and address of the agent, stone	.,	
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / tinodit	(a) 1 dipose	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(O) / timodine	(a) 1 diposes	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
	_		
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / unoun	(4)	3345
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
		Fees and other commissions paid	() 0
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(1)	(2)	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
		ent value of plan's interest under this contract in separate accounts at year e		5		
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page 4	
ployer(s) or members of the same employee or rience-rated as a unit. Where contracts cover s a unit for purposes of this report.	

	li ir	Welfare Benefit Contract Informat f more than one contract covers the same gr nformation may be combined for reporting pu he entire group of such individual contracts v	oup of employees of the surposes if such contracts a	re experienc	e-rated as a unit. Whe	re contracts	
8	Benefit ar	nd contract type (check all applicable boxes)					
	a He	alth (other than dental or vision)	b Dental	С	Vision	(d Life insurance
	e 🗌 Tei	mporary disability (accident and sickness)	f X Long-term disability	/ g	Supplemental unemp	loyment I	h Prescription drug
	i Sto	pp loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract
	m 🗌 Otl	her (specify)					
9	Experienc	e-rated contracts:					
	a Premi	iums: (1) Amount received		9a(1)			
	. ,	crease (decrease) in amount due but unpaid		9a(2)			
		crease (decrease) in unearned premium res	_				
		arned ((1) + (2) - (3))				9a(4)	
	b Bene	efit charges (1) Claims paid	<u>-</u>	9b(1)			_
	` '	crease (decrease) in claim reserves	I				
		curred claims (add (1) and (2))				9b(3)	
	` '	laims charged				9b(4)	
		ainder of premium: (1) Retention charges (o	´ F				4
	(A) Commissions		9c(1)(A)			<u> </u>
	(B) Administrative service or other fees		9c(1)(B)			<u> </u>
	,	C) Other specific acquisition costs	F	9c(1)(C)			<u> </u>
	(D) Other expenses		9c(1)(D)			4
	`	E) Taxes	F	9c(1)(E)			4
	•	F) Charges for risks or other contingencies	-	9c(1)(F)			<u> </u>
		G) Other retention charges	L	9c(1)(G)			
	,	H) Total retention			F	9c(1)(H)	
		Dividends or retroactive rate refunds. (These				9c(2)	
	d Stati	us of policyholder reserves at end of year: (1) Amount held to provide b	enefits after	retirement	9d(1)	
	(2) C	Claim reserves				9d(2)	
	` ,	Other reserves			F	9d(3)	
		dends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e	
10		erience-rated contracts:			F		
		I premiums or subscription charges paid to c			F	10a	14905
		e carrier, service, or other organization incurr ntion of the contract or policy, other than repo				10b	
	Specify	nature of costs •					

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

Schedule A (Form 5500) 2013

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

Form 5500

Department of the Treasury Internal Revenue Service

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4005 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).

OMB Nos.1210-0110 1210-0089

2042

Employee Benefils Security Administration	enerile Security deltration the Instructions to the Form 5500,				
Possion Benefit Guaranty Corporation	tise Instruct	This Form is Open to Public Inspection			
配置 Annual Report I	dentification information		***************************************		
For calendar plan year 2013 or fis	cal plan year beginning	07/01/2013	and ending 06/3	0/2014	
A This return/report is for:	a multiemployer plan;	a multiple-er	nployer plan; or		
	🕱 a single-employer plan;	a DFE (spec	elfy)		
B This return/report is:	the first return/report; an amended return/report;	the final retu a short plan	rn/report; year return/report (less than	12 months).	
C If the plan is a collectively-barge	ained plan, check here			▶⊠	
D Check box if filling under;	Form 5558; special extension (enter descripti	automatic er	klension;	lhe DFVC program;	
Day Deals Dies Info	<u> </u>				
*	mation enter all requested in	ntormation	·	dh = 1	
1a Name of plan	and Dama disable an			1b Three-digit plan	
Handex Consulting a	nd wewedration			number (PN) ► 502	
				10 Effective date of plan 07/01/2007	
2a Plan sponsor's name and ad	dress; include room or suite number	(employer, if for a sing	gle-employer plan)	2b Employer Identification	
				Number (EIN) 20-3908055	
Handex Consulting a	nd Remediation			20 Sponsor's telephone	
				number	
				(321) 441-9801	
1350 Orange Ave				2d Business code (see	
#101				- Instructions)	
US Winter Park	FL 32789			562000	
	A CONTRACTOR OF THE CONTRACTOR				
	incomplete filing of this returnirep				
Under penalties of perjury and othe statements and attachments, as we	er penalties set forth in the instruction all as the electronic version of this ret	s, I declare that I have urn/report, and to the	examined this return/report best of my knowledge and b	Including accompanying schedules, ellef, it is true, correct, and complete.	
IS GN V	M 120	1/09/15	David Misteri	, , , , , , , , , , , , , , , , , , ,	
Signature of plan auti	ninistrator /	Date		lgning as plan administrator	
	Ateo	1/29/5	David Misteri	igning at plan activilisticity	
Signature of employe	or/olan sponsor	Dale		igning as employer or plan sponsor	
reign Merc			arrest statistics of statements	grang do omployes or plant specieur	
Signature of DFE		Date	Enter name of individual s	laning as DEF	
7.25.7	name, if applicable) and address; incl	<u> </u>	nber. (optional) Pr	eparer's telephone number ptional)	
Lassiter Ware, Inc			. ~		
2701 Maitland Center F	arkway			(407) 628-3441	
祥125 			<u> </u>		
US Maitland	FI 32751				
<u> </u>	ATTENDED TO THE PARTY OF THE PA	and the second s			

	Form 5500 (2013) 130118				<u>P</u>	age 2					
3a	Plan administrator's name and address	X Same as Plan Sponsor Name		Sa	me a	s Plan Sj	onsor/	Address	3	3b Ad	iministrator's EiN
										3c Ad	lministrator's telephone mber
4	If the name and/or EtN of the plan sponsor h the plan number from the last return/rep	nas changed since the last return/repo ort;	rt filed f	or this	plan,	enter the	name, I	EIN and		4b Ell	N
a	Sponsor's name									4c PN	V
5	Total number of participants at the begin	ining of the plan year	,							5	161
6	Number of participants as of the end of t	he plan year (welfare plans comple	te only	linea	6a, 6	3b, 6c, a	nd 6d).		•		MURICALIAN
a	Active participants	• • • • • • • • • •		• •			. , .			6a	160
	Retired or separated participants received									6b	
C	Other retired or separated participants e	ntitled to future benefits	, ,			• •		• •	• •	6c	
d	Subtotal. Add lines 6a, 6b, and 6c ,		• •			• • •		• •	• •	6d	160
e	Deceased participants whose beneficiar	es are receiving or are entitled to re	eceive	bene	fits			• •	• •	6e	
f	Total. Add lines 6d and 6e		• •			• •				6f	
g	Number of participants with account bala complete this item)	ances as of the end of the plan year			ed co	ntribution	plans			6g	
h	Number of participants that terminated e less than 100% yested									6h	
7	Enter the total number of employers obli-	gated to contribute to the plan (only	/ multle	mplo	yer p	lans com	plete th	ls Item))	7	
. t	If the plan provides pension benefits, en If the plan provides welfare benefits, en 4A 4B 4D 4E 4E 4E	ter the applicable welfare feature c	odes fr	om th	ne Ljs	it of Plan	Charac	leristics	God	es in the	instructions:
Øđ	Plan funding arrangement (check all the (1)	stahhià)	9b	(1)		alit arran nsurance		. (cneck	an in	at apply)	
	(2) Code section 412(e)(3) insuran	ice contracts	ŀ	(2)	1-1	Code sec		2(e)(3) I	nsura	nce cont	racts
	(3) Trust			(3)	\Box	Trust		-(-)(-)			
	(4) X General assets of the sponsor	· · · · · · · · · · · · · · · · · · ·	L	(4)	X C	General a	o sleae	f the sp	onso	'	······
10	Check all applicable boxes in 10a and 10b	to indicate which achedules are attact	ied, and	d, whe	re Inc	licaled, er	nter the r	numbor	altach	ed. (See i	Instructions)
Ø	Pension Schedules		b	Gor	oral	Schedul	es				
	(1) R (Rethrement Plan Information	1)		(1)	Ц		H (Fina	ancial l	nform	ation)	
	(2) MB (Mulliemployer Defined Ber Purchase Plan Actuarial Inform actuary			(2) (3)	×	<u>8</u>	•	ancial ir urance			mali Plan)
	<u> </u>	n Armst K. C. C.		(4)	Н					informa	•
	(3) SB (Single-Employer Defined Enformation) - signed by the pla	senetit Plan Actuarial in actuary		(5) (6)	H						nformation) :hodules)
				1"/			~ W III	MIMMI	. 441193	AVIOLI 130	1 vadios)

Sponsor Location Information

Sponsor name:

Handex Consulting and Remediation

Sponsor DBA name: Sponsor care of name:

> 1350 Orange Ave Suite 101 US Winter Park

FL 32789

Attachment to 2013 Form 5500 Form M-1 Compliance Information

ΡI	an Name Handex Consulting and Remediation	EIN: 203908055	
ΡI	an Sponsor's Name Handex Consulting and Remediation	_{PN:} 502	
1.	If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year?	Yes No ✓	
	If "Yes" is checked, complete lines 2 and 3.		
2.	Is the plan currently in compliance with Form M-1 filing requirements?	Yes No	
3.	required to file the 2013 M-1 annual report, enter the Receipt Confirmation C recent Form M-1 that was required to be filed under the Form M-1 filing required.	er the Receipt Confirmation Code for the 2013 From M-1 annual report. If the plan was not ired to file the 2013 M-1 annual report, enter the Receipt Confirmation Code for the most nt Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure of a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as implete.)	
	Receipt Confirmation Code		

5500 Electronic Filing Authorization

Plan Name:

Handex Consulting and Remediation

EIN/PN:

20-3908055/502

Plan Year:

07/01/2013 - 06/30/2014

I hereby authorize Kristen M. Hughes to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500 for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure,

E 1811 Samilia

1/20/10

(date)

Plan Spons

1/09/15