Form 5500 Annual Return/Report of Employee Benefit Plan				OMB Nos. 1210-0110		
101113500	•	employee benefit plans under sections 104		12	10-0089	
Department of the Treasury Internal Revenue Service		nt Income Security Act of 1974 (ERISA) and (a) of the Internal Revenue Code (the Code).		2014		
Department of Labor Employee Benefits Security Administration		ntries in accordance with ns to the Form 5500.				
Pension Benefit Guaranty Corporation			This	Form is Open to Pu Inspection	ıblic	
Part I Annual Report Ide	ntification Information			•		
For calendar plan year 2014 or fiscal	plan year beginning 01/01/2014	and ending 12/31/20)14			
A This return/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking participating employer information in acco			ons); or	
	🗙 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-bargain	— ned plan, check here			• 🗌		
D Check box if filing under:	× Form 5558;	automatic extension;	the DFVC program;			
c .	special extension (enter description)					
Part II Basic Plan Infor	mation—enter all requested information	on				
1a Name of plan C.W. ROBERTS CONTRACTING, IN			1b	Three-digit plan number (PN) ▶	501	
			1c	Effective date of pla 01/01/2007	an	
2a Plan sponsor's name and addres C.W. ROBERTS CONTRACTING, IN	ss; include room or suite number (emplo NC	oyer, if for a single-employer plan)	2b	Employer Identifica Number (EIN)	tion	
			59-1683951 2c Plan Sponsor's telephone number		phone	
		AL CIRCLE NE SEE, FL 32308		850-385-5060)	
TALLAHAOOLL, I L 02000		5LL, 1 L 02000	2d	Business code (see instructions) 237310	9	

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.			
HERE	Signature of plan administrator	Date	Enter name of individu	al signing as plan administrator
SIGN HERE				
HERE	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor
SIGN HERE				
HERE	Signature of DFE	Date	Enter name of individu	al signing as DFE
Prepare	's name (including firm name, if applicable) and address (include r	room or suite numbe	r) (optional)	Preparer's telephone number
M. CRAI	G SCARBROUGH, CPA			(optional) 334-792-2153
MCDAN	EL & ASSOCIATES, P. C.			334-792-2133
P. O. BC Dothan	0X 6356 N, AL 36302-6356			

3a	Plan administrator's name and address Same as Plan Sponsor	3b Administrator's EIN		
			ninistrator's telephone nber	
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:	4b EIN	I	
а	Sponsor's name	4c PN		
5	Total number of participants at the beginning of the plan year	5	252	
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).			
a(*	1) Total number of active participants at the beginning of the plan year	. 6a(1)	252	
a(2) Total number of active participants at the end of the plan year	. 6a(2)	233	
b	Retired or separated participants receiving benefits	. 6b		
С	Other retired or separated participants entitled to future benefits	. 6C		
d	Subtotal. Add lines 6a(2), 6b, and 6c.	. 6d	233	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e		
f	Total. Add lines 6d and 6e .	. 6f		
g	Number of participants with account balances as of the end of the plan year (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 Cod	las in tha i	netructione:	

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 4E 4F 4Q

9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)						ngement (check all that apply)		
	(1)	X	Insurance		(1)	X	In	surance
	(2)		Code section 412(e)(3) insurance contracts		(2)		С	ode section 412(e)(3) insurance contracts
	(3)	Π	Trust		(3)		T	rust
	(4)	X	General assets of the sponsor		(4)	X	G	eneral assets of the sponsor
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						licated, enter the number attached. (See instructions)	
a Pension Schedules				b General Schedules				
	(1)		R (Retirement Plan Information)		(1)			H (Financial Information)
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)			I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X		A (Insurance Information)
			actuary		(4)	X		C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)			G (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
	11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)					
If "Yes" is checked, complete lines 11b and 11c.						
11b Is the plan	currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_

SCHEDULE A	•	Insuran	ce Information	n		10	MB No. 1210-0110
(Form 5500)		This schedule is required to be filed upday section 404 of the					
Department of the Treasury Internal Revenue Service		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2014
Department of Labor Employee Benefits Security Admini	istration	File as an attachment to Form 5500.					
Pension Benefit Guaranty Corpor	ration	 Insurance companies a pursuant to E 	are required to provide t ERISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 2014	or fiscal plan	year beginning 01/01/2014		and er	iding 12	2/31/2014	1
A Name of plan C.W. ROBERTS CONTRACT	TING, INC. F	LEXIBLE BENEFITS PLAN			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name as s C.W. ROBERTS CONTRACT		2a of Form 5500		D Emplo 59-168		cation Number	(EIN)
		ing Insurance Contract					
1 Coverage Information:							
(a) Name of insurance carrie		CANADA					
(c) NAIC (d) Contract or (e) Approximate number of Policy or contract year				contract year			
(b) EIN	(c) NAIC code	identification number	persons covered a policy or contract		(f)	From	(g) To
38-1082080 80	0802	234162	222		01/01/20)14	12/31/2014
2 Insurance fee and commis descending order of the an		tion. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total amo	ount of comm	nissions paid		(b) To	otal amount	of fees paid	
		13351					0
3 Persons receiving commis	ssions and fe	es. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	s were paid	
UNITED TRUST INSURANC	CE COMPAN		RIVERCHASE PKWY INGHAM, AL 35244				
(b) Amount of sales and b	base		es and other commission				4
commissions paid	40054	(c) Amount		(d) Purpos	е		(e) Organization code
	13351						3
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	1
		For	es and other commission	ns naid			
(b) Amount of sales and t commissions paid	base	(c) Amount		(d) Purpos	e		(e) Organization code

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

(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			
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
 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		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			l
			1

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Ρ	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	ay be treated as a un	it for purposes of
		this report.		-	
		ent value of plan's interest under this contract in the general account at year of			
•		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6		tracts 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			
	d	If the carrier, service, or other organization incurred any specific costs in cor			
		retention of the contract or policy, enter amount.	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	l annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	intained in separate accounts)		
	а		te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier(3) Transferred to separate account	7e(2)		
		(4) Other (specify below)	7e(3)		
		r			
				70(5)	
	f	(5) Total deductions		7e(5) 7f	0
		Dalance alone end of the content year (Subtract the 7eco) from the 70			

	Page 4	
n		

Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts of	oup of employees of the s urposes if such contracts a	are experienc	e-rated as a unit. Wh	ere contrac	ployee organizations(s), th ts cover individual employ	ne ees,
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance	
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	ployment	h Prescription drug	
	i D	Stop loss (large deductible)	j 🗍 HMO contract	∕u_ k	PPO contract		I Indemnity contract	
	m[Other (specify)						
	[
9	Expe	erience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid	ł	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)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)				_	
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		9c(1)(B)			_	
		(C) Other specific acquisition costs		9c(1)(C)			_	
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes		9c(1)(E)			_	
		(F) Charges for risks or other contingencies		9c(1)(F)			_	
		(G) Other retention charges	L	9c(1)(G)		0-(4)(1)		
		(H) Total retention	_					
		(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1	, ·					
		(2) Claim reserves						
	-	(3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	i in line 9c(2)	.)	9e		
10		nexperience-rated contracts:	orrior.			100		00540
	a b	Total premiums or subscription charges paid to o				10a	1	33513
	IJ	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				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
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE		Insuranc	e Information		ON	/B No. 1210-0110
(Form 5500) Department of the Treasur		This schedule is required	to be filed under section 104 o	f the		2014
Internal Revenue Service			ome Security Act of 1974 (ERI			2014
Department of Labor Employee Benefits Security Admi		File as an at	tachment to Form 5500.		This For	rm is Open to Public
Pension Benefit Guaranty Corp	poration		re required to provide the inforr RISA section 103(a)(2).	nation		Inspection
For calendar plan year 2014	4 or fiscal plan	year beginning 01/01/2014	_	Ŭ	2/31/2014	Γ
A Name of plan C.W. ROBERTS CONTRAC	CTING, INC. F	LEXIBLE BENEFITS PLAN		nree-digit an number (P	N) 🕨	501
C Plan sponsor's name as C.W. ROBERTS CONTRAC		e 2a of Form 5500		ployer Identifie 1683951	cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance carr	ier					
AFLAC						
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	(g) To
58-0663085	60380	D0793	196 01/01/20		014	12/31/2014
		tion. Enter the total fees and tota	I commissions paid. List in line	3 the agents	, brokers, and c	other persons in
descending order of the a	amount paid. nount of comn	nissions paid	(b)	Total amount	of fees paid	
		18135				369
3 Persons receiving comm	issions and fe	ees. (Complete as many entries a	as needed to report all persons).		
	(a) Name a	nd address of the agent, broker, o	•	issions or fees	s were paid	
VARIOUS OTHERS		VARIC VARIC	DUS DUS, FL 00000			
						·
(b) Amount of sales and			and other commissions paid			
commissions paid	3497	(c) Amount	(d) Purp	ose		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to whom comm	issions or fee	s were paid	·
DANIEL S ADAMS			SCOTT CHURCH RD NNA, FL 32448			
(b) Amount of sales and	base	Fees	and other commissions paid			
commissions paid		(c) Amount	(d) Purp	ose		(e) Organization code
	2674	55				3

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

ALLEN MOONEY AND BARNES LLC

318 N CALHOUN ST TALLAHASSEE, FL 32301

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid 2462	(c) Amount 7	(d) Purpose	code 3	
(a) Na	4245	r, or other person to whom commissions or fees were paid MILGEN RD MBUS, GA 31907		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
1671	55		3	
(a) Na		r, or other person to whom commissions or fees were paid MACARTHUR AVE		
	PANA	MA CITY, FL 32401		
(b) Amount of sales and base		Fees and other commissions paid		
commissions paid 1559	(c) Amount 100	(d) Purpose	code 3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
STEVEN FALATCO		ANDS END Z, KY 42211		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
1541			3	
(a) Na		r, or other person to whom commissions or fees were paid		
BRIAN ANDREWS	5728 PACE	TAMARACK DR , FL 32571		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

55

3

1213

Schedule A (Form	5500	2014

Page **2 -** 2

	2014		
(a) Na	me and address of the agent broke	r, or other person to whom commissions or fees were pai	d
ROBERT D PRIVETTE	8727 1	THOMAS DR NUMBER E11	u
	PANA	MA CITY BEACH, FL 32408	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1051	97		3
(a) Na TJM BENEFITS		r, or other person to whom commissions or fees were pai 0X 16552	d
		MA CITY, FL 32406	
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
771	(c) / unounc		3
		r, or other person to whom commissions or fees were pai	d
TAMMY S GARDNER		DX 912 FLAND, FL 32644	
	011121		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
610			3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	d
PAMELA S FALATCO	137 C	ANDLEWICK	4
	PANA	MA CITY, FL 32405	
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
569			3
		r, or other person to whom commissions or fees were pai	d
VICTORIA J LENCE		RVARD CIRCLE MA CITY, FL 32466	
			I
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Ρ	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	ay be treated as a un	it for purposes of
		this report.		-	
		ent value of plan's interest under this contract in the general account at year of			
•		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6		tracts 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			
	d	If the carrier, service, or other organization incurred any specific costs in cor			
		retention of the contract or policy, enter amount.	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	l annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	intained in separate accounts)		
	а		te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier(3) Transferred to separate account	7e(2)		
		(4) Other (specify below)	7e(3)		
		r			
				70(5)	
	f	(5) Total deductions		7e(5) 7f	0
		Dalance alone end of the content year (Subtract the /eco) from the /o)			

		Schedule A (Form 5500) 2014		Ра	ge 4			
Pa	rt II	II 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	roup of employees of the urposes if such contracts	are experienc	e-rated as a unit. Wh	ere contract		
8	Ben	efit and contract type (check all applicable boxes)	1					
	a	Health (other than dental or vision)	b Dental	с×	Vision		d X Life insuranc	e
	e	 Temporary disability (accident and sickness) 	f Long-term disabil	ity g	Supplemental unem	ployment	h Prescription	drug
	iΪ	Stop loss (large deductible)	j 🗍 HMO contract	k [PPO contract		I Indemnity co	ntract
	m	X Other (specify) CANCER					—	
	Ľ							
9	Expe	erience-rated contracts:						
	a	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)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		. 9b(1)				
		(2) Increase (decrease) in claim reserves		. 9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	on an accrual basis)					
		(A) Commissions		. 9c(1)(A)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs						
		(D) Other expenses						
		(E) Taxes						
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		_ 9c(1)(G)		1		
		(H) Total retention				9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These	e amounts were 🔤 paid i	n cash, or 🗌	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	I) 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 not	ot include amount entere	d in line 9c(2)	.)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	carrier			10a		106712
	b	If the carrier, service, or other organization incurr						
		retention of the contract or policy, other than repo	orted in Part I, line 2 abov	ve, report amo	ount	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
12 If the	answer to line 11 is "Yes," specify the information not provided. 🕨			

SCHEDULE	Α	Insuran	ce Information	n			IR No. 1210 0110
(Form 5500)							1B No. 1210-0110
Department of the Treasur Internal Revenue Service		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2014
Department of Labor Employee Benefits Security Admi	inistration	File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Corp	poration	 Insurance companies a pursuant to E 	are required to provide to ERISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 2014	4 or fiscal plan	year beginning 01/01/2014		and en	ding 12	/31/2014	
A Name of plan C.W. ROBERTS CONTRAC	CTING, INC. F	ELEXIBLE BENEFITS PLAN			e-digit number (Pl	N) ►	501
C Plan sponsor's name as C.W. ROBERTS CONTRAC		e 2a of Form 5500		D Emplo 59-168		ation Number	(EIN)
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance carr	ier						
AMERITAS LIFE INSURA	NCE CORP						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From		(g) To
47-0098400	61301	010-030063	13	39	01/01/20	14	12/31/2014
2 Insurance fee and comm descending order of the a		ation. Enter the total fees and tota	al commissions paid. Li	ist in line 3	the agents,	brokers, and c	ther persons in
(a) Total an	nount of comr	nissions paid		(b) To	otal amount	of fees paid	
		3624					(
3 Persons receiving comm	nissions and fe	ees. (Complete as many entries	as needed to report all	persons).			
ALLEN MOONEY AND BA		nd address of the agent, broker,		m commiss	ions or fees	were paid	
ALLEN MOONET AND BA	IRNES LLC	TALL	I CALHOUN ST AHASSEE, FL 32301				
(b) Amount of sales and	base	Fee	es and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code
	3624						3
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	<u> </u>
	[Aa	s and other commission	ns paid			

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice			

Schedule A (Form 5500) 2014 v. 140124

(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		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nan	ne and address of the agent, broke	, 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
 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		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	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		(e) Organization	
	(c) Amount	(d) Purpose	code
			l
			1

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Ρ	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	ay be treated as a un	it for purposes of
		this report.		-	
		ent value of plan's interest under this contract in the general account at year of			
•		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6		tracts 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			
	d	If the carrier, service, or other organization incurred any specific costs in cor			
		retention of the contract or policy, enter amount.	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	l annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	intained in separate accounts)		
	а		te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier(3) Transferred to separate account	7e(2)		
		(4) Other (specify below)	7e(3)		
		r			
				70(5)	
	f	(5) Total deductions		7e(5) 7f	0
		Dalance alone end of the content year (Subtract the 7eco) from the 70			

Page **4**

Part III Welfare Benefit Contract Information If more than one contract covers the same of information may be combined for reporting the entire group of such individual contracts	roup of employees of the sourposes if such contracts	are experien	ce-rated as a unit. Wh	ere contract	
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 disabili		Supplemental unem	olovment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	_	PPO contract		I Indemnity contract
		ĸ			
m ☐ Other (specify) ►					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			4
(2) Increase (decrease) in amount due but unpa					-
(3) Increase (decrease) in unearned premium re					
(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					
(D) Other expenses		9c(1)(D)			
(E) Taxes					4
(F) Charges for risks or other contingencies					4
(G) Other retention charges				0~(1)(U)	
(H) Total retention	_			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (Thes					
d Status of policyholder reserves at end of year: (, ,			9d(1)	
(2) Claim reserves				9d(2)	
(3) Other reserves				9d(3)	
e Dividends or retroactive rate refunds due. (Do 1 10 Nonexperience-rated contracts:	ior include amount entered	u in inte 90(2)	J. J	9e	
a Total premiums or subscription charges paid to	carrier			10a	72483
b If the carrier, service, or other organization incu				iva	12403
retention of the contract or policy, other than re				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	Α	Insuranc	ce Information	n			
(Form 5500)				0	MB No. 1210-0110	
Department of the Treas Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2014
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 20	14 or fiscal plan	year beginning 01/01/2014		and en	ding 12/	31/2014	
A Name of plan C.W. ROBERTS CONTRA	ACTING, INC. F	LEXIBLE BENEFITS PLAN		B Three plan	e-digit number (PN	l) 🕨	501
C Plan sponsor's name a C.W. ROBERTS CONTRA	ACTING, INC			59-168	3951	ation Number	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
USABLE LIFE							
<i>a</i> . _	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To
71-0505232	94358	50012516	23	33	01/01/20	14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents, I	brokers, and	other persons in
	amount of comn	nissions paid		(b) To	tal amount o	of fees paid	
		1485					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
ABLE BENEFIT SOLUTI	ONS		DX 11407 NGHAM, AL 35246				
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pa	id 1093	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
GARY STOREY	(1102 \$	SELKIRK AN, AL 36303				
		Fee	s and other commission	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code
	294						3
For Paperwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for F	Form 5500.		Sch	edule A (Form 5500) 2014

v. 140124

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

RICHARD BYRD

3713 TUDOR LANCE MOBILE, AL 36608

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
98			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		(e) Organization	
	(c) Amount	(d) Purpose	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		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	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		(e) Organization	
	(c) Amount	(d) Purpose	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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Ρ	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	ay be treated as a un	it for purposes of
		this report.		-	
		ent value of plan's interest under this contract in the general account at year of			
•		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6		tracts 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			
	d	If the carrier, service, or other organization incurred any specific costs in cor			
		retention of the contract or policy, enter amount.	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	l annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	intained in separate accounts)		
	а		te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6)).		7d	
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier(3) Transferred to separate account	7e(2)		
		(4) Other (specify below)	7e(3)		
		r			
				70(5)	
	f	(5) Total deductions		7e(5) 7f	0
		Dalance alone end of the content year (Subtract the /eco) from the /o)			

	Schedule A (Form 5500) 2014		Page 4	
Part III	Welfare Benefit Contract Informat 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 urposes if such contracts are ex	perience-rated as a unit. Where contra	
a	t and contract type (check all applicable boxes) Health (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify)	b ☐ Dental f ☐ Long-term disability j ☐ HMO contract	C Vision G Supplemental unemployment K PPO contract	d X Life insurance h ☐ Prescription drug I ☐ Indemnity contract
a Pre	ence-rated contracts: emiums: (1) Amount received) Increase (decrease) in amount due but unpai		a(1) a(2)	_

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)	
k	b Benefit charges (1) Claims paid	9b(1)			
	(2) Increase (decrease) in claim reserves				
	(3) Incurred claims (add (1) and (2))			. 9b(3)	
	(4) Claims charged			. 9b(4)	
C	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				
	(H) Total retention			. 9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These amounts were paid	d in cash, or 🗌 credi	ted.)		
C	d Status of policyholder reserves at end of year: (1) Amount held to provide				
	(2) Claim reserves			. 9d(2)	
	(3) Other reserves				
e	e Dividends or retroactive rate refunds due. (Do not include amount ente			. 9e	
	Nonexperience-rated contracts:	(), ,			
	a Total premiums or subscription charges paid to carrier			. 10a	9796
k	b If the carrier, service, or other organization incurred any specific costs in				
-	retention of the contract or policy, other than reported in Part I, line 2 ab		•	. 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	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

(Form 5500)	SCHEDULE C Service Provider Information			OMB No. 1210-0110	
		2014			
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under Retirement Income Security A				
Department of Labor Employee Benefits Security Administration	File as an attachmen	nt to Form 5500.	This I	Form is Open to Public Inspection.	
Pension Benefit Guaranty Corporation			10011		
for calendar plan year 2014 or fiscal pla Name of plan	an year beginning 01/01/2014		/2014		
C.W. ROBERTS CONTRACTING, INC	. FLEXIBLE BENEFITS PLAN	B Three-digit plan number (PN)	•	501	
Plan sponsor's name as shown on li C.W. ROBERTS CONTRACTING, INC		D Employer Identificati 59-1683951	on Number	(EIN)	
Part I Service Provider Info	ormation (see instructions)				
 plan during the plan year. If a person answer line 1 but are not required to Information on Persons Re Check "Yes" or "No" to indicate whet indirect compensation for which the point of t	noney or anything else of monetary value) in c n received only eligible indirect compensation include that person when completing the rem ceiving Only Eligible Indirect Com her you are excluding a person from the rema blan received the required disclosures (see insor r the name and EIN or address of each persor	n for which the plan received the required ainder of this Part. Ipensation ainder of this Part because they receir structions for definitions and condition n providing the required disclosures the	ved only el	gible	
	nsation. Complete as many entries as needed				
(D) Enter na	ame and EIN or address of person who provid	led you disclosures on eligible indired	ct compens	ation	
(b) Enter na	ame and EIN or address of person who provid	ded you disclosure on eligible indirect	t compensa	tion	
(b) Enter na	ame and EIN or address of person who provid	ded you disclosure on eligible indirect	t compensa	tion	
	ame and EIN or address of person who provid				

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)								
BLUE CRC	BLUE CROSS AND BLUE SHIELD OF AL 450 RIVERCHASE PKWY BIRMINGHAM, AL 35244							
63-010383	0							
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?		
12	CLAIMS PROCESSOR	165684	Yes 🗌 No 🗙	Yes 🗌 No 🗌		Yes 🗌 No 🗌		
		(a) Enter name and EIN or	address (see instructions)				
	_	_						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?		
			Yes No	Yes 🗌 No 🗌		Yes 🗌 No 🗌		
		(a) Enter name and EIN or	address (see instructions)				
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?		
			Yes No	Yes 🗌 No 🗌		Yes 🗌 No 🗌		

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or estimated amount?	
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗌	
	(a) Enter name and EIN or address (see instructions)						

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
			Yes No	Yes No	(t). It none, enter -0	Yes No

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
		compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect of	compensation, including any
	formula used to determine	the service provider's eligibility
		ne indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation		ompensation, including any the service provider's eligibility
		ne indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect of	compensation, including any
	formula used to determine for or the amount of th	the service provider's eligibility ne indirect compensation.

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

Part III		Termination Information on Accountants and Enrolled Actuaries (see in (complete as many entries as needed)	structions)	
а	Name		b EIN:	
С	C Position:			
d	d Address:		e Telephone:	
Explanation:				
Ex	planatio	 1:		

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
-		

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

Form 5500	lan	C	MB Nos. 1210 - 011 1210 - 008			
Department of the Treasury Internal Revenue Service	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					
Department of Labor Employee Benefits Security	sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). Complete all entries in accordance with				014	
Administration Pension Benefit Guaranty Corporation		the instructions to				n is Open to
Part I Annual Report	rt Identification Info	rmation			Public I	nspection
For calendar plan year 2014	or fiscal plan year beginni	ing 01/01/	2014 and ending	12/31	L/2014	
A This return/report is for:B This return/report is:	a multiemployer plan a single-employer pl the first return/repor	an; pa al t; dh	multiple-employer plan (File articipating employer inforn DFE (specify) e final return/report;	ers checking this nation in accorda	box must atta nce with the	ach a list of forms instr.); or
C If the plan is a collection by the	an amended return/	report; as	short plan year return/repo	rt (less than 12 m	nonth <u>s)</u> .	
C If the plan is a collectively-baseD Check box if filing under:	Z Form 5558; special extension (er	au	tomatic extension;	the DFVC pro	▶∐ gram;	
Part II Basic Plan Inf	ormation - enter all rec	uested information				
1a Name of plan C.W. ROBERTS CONT FLEXIBLE BENEFITS	RACTING, INC			1b Three-digit plan number	1 7 7	501
				1c Effective da 01/01/		
2a Plan sponsor's name and addres		ıber (employer, if for a	single-employer plan)	2b Employer lo		
C.W. ROBERTS CONI	RACTING, INC		3	2c Plan Spons 3 5 0 – 3 8 5 – 5	or's telephon 060	e number
3372 CAPITAL CIRC	LE NE			2d Business cc 237310	ode (see instru	uctions)
TALLAHASSEE 3372 CAPITAL CIRC		2308				
TALLAHASSEE		2308				
Caution: A penalty for the late or	r incomplete filing of this	s return/report will !	be assessed unless reaso	onable cause is	established.	
Under penalties of perjury and other penalties as the electronic version of this return/report,	set forth in the instructions, I decl and to the best of my knowledge a	are that I have examined th and belief, it is true, correct,	is return/report, including accompa and complete.	nying schedules, state	ments and attach	ments, as well
SIGN Rolet De	~~~~	08/03/2015	BOB DELISLE	÷		
Signature of plan admini		Date	Enter name of individual s	igning as plan ad	Iministrator	
SIGN HERE						
Signature of employer/pl	an sponsor D	late	Enter name of individual s	igning as employ	er or plan spo	onsor
SIGN						
HERE Signature of DFE		ate	Entor nome of individual		i	
Preparer's name (including firm na			Enter name of individual s or suite number) (optional)		elephone nur	nber
M. CRAIG SCARBRON	JGH, CPA			334-792	2-2153	
MCDANIEL & ASSOC P. O. BOX 6356	LATES, P. C.				Contraction of the second	
P = U = BUX + AAA						

10-13-14

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Form 5500 ((2014)
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3a Plan administrator's name and address X Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number

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:		4b EIN
â	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year		
6	Number of participants at the beginning of the plan year	5	252
-	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only li 6a(1), 6a(2), 6b, 6c, and 6d).		•
a	(1) Total number of active participants at the beginning of the plan year	6a(1)	252
а	(2) Total number of active participants at the end of the plan year		
b	Retired or separated participants receiving bonofite	6a(2)	233
с	Other retired or separated participants receiving benefits	6b	
-	o the retired of separated participants entitled to future benefits	6-	
d			233
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	255
f	Total. Add lines 6d and 6e		
g	Number of participants with account balances as of the and of the order of the second se	6f	
Ŭ	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		
h		6g	
11	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)		
00			

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 4E 4F 4Q

9a 10	Plan funding arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)	 9b Plan benefit arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor are attached, and, where indicated, enter the number attached.
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) 4 A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information) (6) G (Financial Transaction Schedules)

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