#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

Part I	Annual Report Id	entification Information					
For cale	ndar plan year 2014 or fisc	al plan year beginning 01/01/2014		and ending 12/31/20	14		
<b>A</b> This	return/report is for:	a multiemployer plan;		nployer plan (Filers checking temployer information in accordance)			ons); or
		x a single-employer plan;	a DFE (spec	cify)	,		
R This	return/report is:	the first return/report;	the final retu	rn/report;			
D IIIIS	eturr/report is.	an amended return/report;	불	year return/report (less than	12 months	nonths)	
<b>C</b> 16.0						·/·	
	C If the plan is a collectively-bargained plan, check here						
<b>D</b> Chec	k box if filing under:	Form 5558;	X automatic ex	tension;	the DF	VC program;	
		special extension (enter descript	ion)				
Part	II Basic Plan Info	rmation—enter all requested inform	mation				
	1a Name of plan FISHER BROTHERS MANAGEMENT COMPANY LTD & STD				1b	Three-digit plan number (PN) ▶	502
					1c	Effective date of pla 07/01/1990	an
	sponsor's name and addr BROTHERS MANAGEME	ess; include room or suite number (er ENT COMPANY	mployer, if for a single	-employer plan)	2b	Employer Identifica Number (EIN)	tion
						13-1804067	
					<b>2c</b> Plan Sponsor's telephone number		•
	RK AVENUE DRK, NY 10171		RK AVENUE ORK, NY 10171		<u> </u>	212-752-5000	
					2d Business code (see instructions) 531310		
Caution	: A penalty for the late or	incomplete filing of this return/rep	ort will be assessed	unless reasonable cause is	s establis	hed.	
		er penalties set forth in the instructions ell as the electronic version of this retu					
SIGN HERE	Filed with authorized/valid	electronic signature.	10/12/2015	SUSAN DALTON			
	Signature of plan admir	nistrator	Date	Enter name of individual si	igning as	plan administrator	
SIGN							
HERE	Signature of employer/	plan sponsor	Date	Enter name of individual si	igning as	emplover or plan sp	onsor
	organism of the project				<u>gg</u>		
SIGN							
HERE	Signature of DFE		Date	Enter name of individual si	igning oc	DEE	
Preparei		me, if applicable) and address (include				elephone number	
•	, ,				ptional)	·	

Form 5500 (2014) Page **2** 

3a	Plan administrator's name and address Same as Plan Sponsor			<b>3b</b> Administr	ator's EIN
				3c Administra	ator's telephone
4	If the name and/or EIN of the plan sponsor has changed since the last return/report:	report filed for	r this plan, enter the name,	4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year			5	547
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2), 6b, 6c,</b> and <b>6d</b> ).	(welfare plans	s complete only lines 6a(1),		
a(1	) Total number of active participants at the beginning of the plan year			6a(1)	
a(2	Total number of active participants at the end of the plan year			6a(2)	547
b	Retired or separated participants receiving benefits			. 6b	
С	Other retired or separated participants entitled to future benefits			. 6с	
d	Subtotal. Add lines 6a(2), 6b, and 6c.			. 6d	547
е	Deceased participants whose beneficiaries are receiving or are entitled to receiving	eive benefits.		. 6e	
f	Total. Add lines 6d and 6e.			. 6f	547
g	Number of participants with account balances as of the end of the plan year (complete this item)			. 6g	
	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 m	nultiemployer	plans complete this item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature code  If the plan provides welfare benefits, enter the applicable welfare feature code  4F 4H	es from the Lis	st of Plan Characteristics Code	s in the instruct	
9a	Plan funding arrangement (check all that apply)  (1)	9b Plan be (1)	nefit arrangement (check all that	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance conti	racts
	(3) Trust	(3)	Trust		
	(4) General assets of the sponsor	(4)	General assets of the sp		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are att	tached, and, v	where indicated, enter the numl	ber attached. (	See instructions)
а	Pension Schedules	<b>b</b> Genera	al Schedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform	nation – Small F	Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X _5 A (Insurance Infor	,	
	actuary	(4)	C (Service Provide		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) (6)	D (DFE/Participati	_	
	Information) - signed by the plan actuary	(6)	(Financial Irans	saction Schedul	E0)

Form 5500 (2014) Page **3** 

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					

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

2014

			ERISA section 103(a)(2).		Inspection		
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2014	and e	nding 12/31/2014			
A Name of plan FISHER BROTHERS MAI	-			ee-digit n number (PN)	502		
C Plan sponsor's name a FISHER BROTHERS MAI				loyer Identification Numbe 804067	r (EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca	rrier						
CIGNA LIFE INSURANC	E COMPANY C	OF NEW YORK					
(L) [IN]	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To		
13-2556568	64548	VDY960021	544	01/01/2014	12/31/2014		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. List in line 3	3 the agents, brokers, and	other persons in		
	(a) Total amount of commissions paid (b) Total amount of fees paid						
		11472					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all persons).				
	(a) Name a	nd address of the agent, broker	, or other person to whom commis	sions or fees were paid			
CORPORATE CONSULT	ΓING SERVICE		3RD AVENUE / YORK, NY 10158				
(b) Amount of sales a	nd hase	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Purpose		(e) Organization code		
	11472	S	ALES & SERVICE				
	(a) Name a	and address of the agent, broker	or other person to whom commis	sions or fees were naid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code		

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page <b>2 -</b> 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as 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	
_		tracts With Allocated Funds:			•	1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred  (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			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	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2014		Page <b>4</b>		
rt III Welfare Benefit Contract Info If more than one contract covers the sa information may be combined for report the entire group of such individual cont	ame group of employees of the string purposes if such contracts	are experience-rated	as a unit. Where contra	
Benefit and contract type (check all applicable by	ooxes)			
a Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision		<b>d</b> Life insurance
e Temporary disability (accident and sicknown)	ess) <b>f</b> Long-term disabilit	ty <b>g</b> Supple	emental unemployment	h Prescription drug
i Stop loss (large deductible)	j  HMO contract	<b>k</b>		I  Indemnity contract
m X Other (specify) ▶SHORT TERM DISAB	BILITY			_
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but	unpaid	9a(2)		
(3) Increase (decrease) in unearned premi	um reserve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
<b>b</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 char				
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees	3	9c(1)(B)		
(C) Other specific acquisition costs		9c(1)(C)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

76484

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

10 Nonexperience-rated contracts:

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

(C) Other specific acquisition costs ..... (D) Other expenses.....

(E) Taxes.....

(F) Charges for risks or other contingencies.....

(H) Total retention.....

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.).....

(2) Claim reserves .....

(3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier ......

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement ......

Part III

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

9c(1)(D) 9c(1)(E)

9c(1)(F)

<sup>12</sup> 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

2014

pursuant to ERISA section 103(a)(2).				inspection			
For calendar plan year 20°	14 or fiscal pla	n year beginning 01/01/2014	_	and endi	ng 12	2/31/2014	
A Name of plan FISHER BROTHERS MAN	NAGEMENT C	OMPANY LTD & STD		B Three-	digit umber (Pl	N) <b>•</b>	502
C Plan sponsor's name a FISHER BROTHERS MAN				D Employe 13-1804		cation Number (I	EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca	rrier						
CIGNA LIFE INSURANCI	E COMPANY (	OF NEW YORK					
/h) FINI	(c) NAIC	(d) Contract or	(e) Approximate nun			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered at a policy or contract y		(f)	From	<b>(g)</b> To
13-2556568	64548	NYK600126	544	ļ	01/01/20	)14	12/31/2014
2 Insurance fee and complete descending order of the		ation. Enter the total fees and to	tal commissions paid. Lis	t in line 3 th	e agents,	brokers, and ot	her persons in
(a) Total a	amount of com	missions paid		(b) Tota	al amount	of fees paid	
		575					
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all pe	ersons).			
		and address of the agent, broker	, or other person to whom	commissio	ns or fees	were paid	
CORPORATE CONSULT	ING SERVICE		3RD AVENUE / YORK, NY 10158				
(b) Amount of sales ar	nd hase	Fe	es and other commissions	paid			
commissions pai		(c) Amount	(d) Purpose		(e) Organization code		
575 SALES & SERVICE							
	(a) Name a	and address of the agent, broker	or other person to whom	commissio	ns or fees	were paid	
(b) Amount of sales ar	nd base	Fe	es and other commissions	paid			
commissions pai		(c) Amount	(0	d) Purpose			(e) Organization code

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page <b>2 -</b> 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as 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	
_		tracts With Allocated Funds:			•	1
	а	State the basis of premium rates				
	b	Premiums paid to carrier		6b		
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶					
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			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	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2014		Pa	ge <b>4</b>		
Welfare Benefit Contract Information If more than one contract covers the same gonformation may be combined for reporting pothe entire group of such individual contracts	roup of employees of the sar urposes if such contracts are	e experienc	e-rated as a unit. Where co	ontracts cov	• • • • • • • • • • • • • • • • • • • •
efit and contract type (check all applicable boxes)					
Health (other than dental or vision)	<b>b</b> Dental	С	Vision	d 🗌	Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemploym	ent <b>h</b>	Prescription drug
Stop loss (large deductible)	j  HMO contract	k	PPO contract	ıΠ	Indemnity contract
Other (specify) SHORT TERM DISABILITY	- <b>L</b>			<u>—</u>	
<b>_</b>					
erience-rated contracts:	_				
Premiums: (1) Amount received	<u> </u>	9a(1)			
(2) Increase (decrease) in amount due but unpai	d	9a(2)			
(3) Increase (decrease) in unearned premium res	serve	9a(3)			
(4) Earned ((1) + (2) - (3))			9	a(4)	
Benefit charges (1) Claims paid		9b(1)			
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))			91	o(3)	
(4) Claims charged			91	o(4)	
Remainder of premium: (1) Retention charges (c	on an accrual basis)				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees		9c(1)(B)			
(C) Other specific acquisition costs	5	9c(1)(C)	_		

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

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

10 Nonexperience-rated contracts:

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

Experience-rated contracts:

m X Other (specify) ▶SHORT TERM DISABILITY

a Premiums: (1) Amount received...... (2) Increase (decrease) in amount due but unpaid.....

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.....

(E) Taxes.....

(F) Charges for risks or other contingencies.....

(H) Total retention..... (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.).....

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement ......

(2) Claim reserves .....

(3) Other reserves.....

Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

Part III

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

9c(1)(D)

9c(1)(E)

9c(1)(F)

<sup>12</sup> 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

2014

			ERISA section 103(a)(2).	lation	Inspection
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2014	and	ending 12/31/2014	
A Name of plan FISHER BROTHERS MA	NAGEMENT C	COMPANY LTD & STD		ree-digit an number (PN)	502
C Plan sponsor's name a FISHER BROTHERS MA				ployer Identification Numb 804067	er (EIN)
			Coverage, Fees, and Cor s a unit in Parts II and III can be re		
1 Coverage Information:					
(a) Name of insurance ca					
CIGNA LIFE INSURANC	E COMPANY	OF NEW YORK	T		
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		or contract year
(2) 2	code	identification number	policy or contract year	(f) From	<b>(g)</b> To
13-2556568	64548	VDY960057	544	01/01/2014	12/31/2014
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. List in line	3 the agents, brokers, ar	d other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid					I
		9882			
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all persons)		
			r, or other person to whom commi	ssions or fees were paid	
CORPORATE CONSUL	TING SERVICI		3RD AVENUE V YORK, NY 10158		
(b) Amount of sales a commissions page		(c) Amount	ees and other commissions paid (d) Purpo	200	(e) Organization code
commissions pa	9882	1	SALES & SERVICE	JSE	(e) Organization code
	(a) Name	and address of the agent, broke	r, or other person to whom commi	ssions or fees were paid	
(b) Amount of sales a	nd hase	Fe	es and other commissions paid		
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code

Schedule A (Form 5500)	2014	Page <b>2 -</b> 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
	-					
(b) Amount of sales and base		Fees and other commissions paid	(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						
	<u> </u>					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(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						
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as 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	
_		tracts With Allocated Funds:			•	1
	а	State the basis of premium rates				
	b	Premiums paid to carrier		6b		
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶					
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			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	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2014		Page <b>4</b>		
rt III Welfare Benefit Contract Inform If more than one contract covers the same information may be combined for reporting the entire group of such individual contract	group of employees of the spurposes if such contracts a	are experience-rate	d as a unit. Where contrac	
Benefit and contract type (check all applicable boxe	<u>.</u> ;s)			
a Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Visio	n	<b>d</b> Life insurance
e Temporary disability (accident and sickness)	f Long-term disabilit	y <b>g</b> Supp	lemental unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k∏ PPO		I  Indemnity contract
m X Other (specify) ▶SHORT TERM DISABILIT	- <b>-</b>			
The Other (specify) Forfort Term Bloadlett				
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unp	aid	9a(2)		
(3) Increase (decrease) in unearned premium	reserve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
<b>b</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)	
<b>c</b> Remainder of premium: (1) Retention charges	(on an accrual basis)	ı		
(A) Commissions	<b>⊢</b>	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)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

65885

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

10 Nonexperience-rated contracts:

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

(E) Taxes.....

(F) Charges for risks or other contingencies.....

(H) Total retention.....

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.).....

(2) Claim reserves .....

(3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier ......

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement ......

Part III

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

9c(1)(E)

9c(1)(F)

<sup>12</sup> 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

2014

			ERISA section 103(a)(2).	ation	Inspection
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2014	and e	ending 12/31/2014	
A Name of plan FISHER BROTHERS MAI	NAGEMENT CO	OMPANY LTD & STD		ee-digit n number (PN)	502
C Plan sponsor's name a FISHER BROTHERS MAI	NAGEMENT CO	OMPANY	13-18	loyer Identification Number 304067	
			Coverage, Fees, and Cons a unit in Parts II and III can be rep		
1 Coverage Information:	le Scriedule A.	individual contracts grouped as	s a unit in Farts if and in can be rep	ported on a single Scriedul	IC A.
(a) Name of insurance ca	rrier				
CIGNA LIFE INSURANC	E COMPANY C	OF NEW YORK			
/L) FIN	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To
13-2556568	64548	VDY960022	544	01/01/2014	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. List in line 3	3 the agents, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid					
		4885			
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all persons).		
			, or other person to whom commis	ssions or fees were paid	
CORPORATE CONSULT	TING SERVICE		3RD AVENUE / YORK, NY 10158		
(b) Amount of sales ar	nd base	Fe	es and other commissions paid		
commissions pa	1	(c) Amount	\	(d) Purpose	
	4855	8	SALES & SERVICE		
	(a) Name a	nd address of the agent, broke	, or other person to whom commis	ssions or fees were paid	
	(a) Name a	nd address of the agent, broker	, or other person to whom commis	ssions of fees were paid	
(b) Amount of sales ar	nd base	Fe	es and other commissions paid		
commissions pa		(c) Amount	(d) Purpo	se	(e) Organization code

Schedule A (Form 5500)	2014	Page <b>2 -</b> 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
	-					
(b) Amount of sales and base		Fees and other commissions paid	(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						
	<u> </u>					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(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						
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	s with each carrier may	be treated	d as 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	
-		tracts With Allocated Funds:			•	ı
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	7.41			
		(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)			
		•				
		(F) Total daductions			7e(5)	
	f	(5) Total deductions			76(3) 7f	

Schedule A (Form 5500) 2014		Page <b>4</b>	
Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting portion that the entire group of such individual contracts of	roup of employees of the saurposes if such contracts a	re experience-rated as a unit. Where contr	. ,
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	<b>b</b> Dental	<b>C</b> Vision	<b>d</b> Life insurance
emporary disability (accident and sickness)	f X Long-term disability	g Supplemental unemployment	<b>h</b> Prescription drug
Stop loss (large deductible)	j HMO contract	<b>k</b> PPO contract	I Indemnity contract
Other (specify)			
nce-rated contracts:			
:··		0-/4\	

8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life in	nsurance
	е	Temporary disability (accident and sickness)	f X Long-term disability	g 🗍	Supplemental unemp	loyment	<b>h</b> Preso	cription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Inden	nnity contract
	m	Other (specify)	_				_	
	_							
9	Ехре	erience-rated contracts:	_					
	а	Premiums: (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))	<u>.</u>			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					_	
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)			_	
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	,	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide b	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line <b>9c(2)</b> .	)	9e		
10	No	onexperience-rated contracts:			•			
		Total premiums or subscription charges paid to c	arrier			10a		85527
	b	If the carrier, service, or other organization incur	red any specific costs in co	nnection witl	n the acquisition or			
		retention of the contract or policy, other than rep				10b		
	Sp	pecify nature of costs						

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

Part III

<sup>12</sup> 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

2014

			ERISA section 103(a)(2).	idation	Inspection
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2014	and e	ending 12/31/2014	
A Name of plan FISHER BROTHERS MAI	NAGEMENT C	COMPANY LTD & STD		ree-digit an number (PN)	502
C Plan sponsor's name a FISHER BROTHERS MAI				oloyer Identification Number 804067	er (EIN)
			Coverage, Fees, and Cors a unit in Parts II and III can be re		
1 Coverage Information:					
(a) Name of insurance ca					
CIGNA LIFE INSURANCE COMPANY OF NEW YORK					
( <b>n</b> ) FIN   ` '		(d) Contract or	(e) Approximate number of persons covered at end of		contract year
(D) EIIV	code	identification number	policy or contract year	(f) From	<b>(g)</b> To
13-2556568 64548 VDY960058		VDY960058	544	01/01/2014	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. List in line	3 the agents, brokers, and	I other persons in
	(a) Total amount of commissions paid (b) Total amount of fees paid				
		4735			
3 Persons receiving com	missions and t	fees. (Complete as many entrie	s as needed to report all persons).		
	(a) Name	and address of the agent, broke	r, or other person to whom commis	ssions or fees were paid	
CORPORATE CONSULT	ΓING SERVICI		3RD AVENUE V YORK, NY 10158		
		Fe	es and other commissions paid		
(b) Amount of sales an commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code
	4735	1	SALES & SERVICE		
	(a) Name	and address of the agent, broke	r, or other person to whom commis	ssions or fees were paid	
(b) Amount of sales a	nd base	Fe	es and other commissions paid		
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code

Schedule A (Form 5500) 2014 Page <b>2 -</b> 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid	•	
(a) Na	line and address of the agent, broke	er, or other person to whom commissions or rees were paid		
		Fees and other commissions paid	T	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
	(0)	(2)		
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(4)	and and address of the agent, protect	n, et estici person to mism commissions et rece maio paid		
(h) American of a class and have		Fees and other commissions paid	(-) () (	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T		1	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	s with each carrier may	be treated	d as 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	
-		tracts With Allocated Funds:			•	ı
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	7.41			
		(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)			
		•				
		(F) Total daductions			7e(5)	
	f	(5) Total deductions			76(3) 7f	

Pa	age <b>4</b>		
e experienc	` ,	ere contracts	loyee organizations(s), the s cover individual employees,
c g k	Vision Supplemental unemp PPO contract	_	d Life insurance h Prescription drug l Indemnity contract
9a(1)			
9a(1)			-
9a(3)			
OF (4)		9a(4)	

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	irposes if such contracts a	re experienc	e-rated as a unit. Whe	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term disability	, g	Supplemental unemp	loyment	<b>h</b> Prescription drug	
	i [	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	<b>⊢</b>					
		(3) Increase (decrease) in unearned premium res	_					
		(4) Earned ((1) + (2) - (3))	_			9a(4)		
	_	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))	<del>-</del>			9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(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 b	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line <b>9c(2)</b> .	.)	9e		
10		nexperience-rated contracts:			i			
	_	Total premiums or subscription charges paid to c				10a		73550
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
	Sp	ecify nature of costs						

Part IV	Provision of Information			
<b>11</b> Did 1	he insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Schedule A (Form 5500) 2014

**Welfare Benefit Contract Information** 

Part III

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