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 Identification Information

For calendar plan year 2014 or fiscal plan year beginning 11/01/2014 and ending 10/31/2015

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
TEAM EMPLOYEES HEALTH AND WELFARE TRUST FUND WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 11/01/2012

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

8530 LA MESA BLVD.,
SUITE 200
LA MESA, CA 91942

2b Employer Identification Number (EIN)
68-0535627

2c Plan Sponsor's telephone number
619-281-1100

2d Business code (see instructions)
525920

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.	02/26/2016	CULLEN KNIGHTS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Preparer's telephone number (optional)

3a Plan administrator's name and address [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	46-6299079
a Sponsor's name TEAM EMPLOYEES HEALTH AND WELFARE TRUST	**4c** PN	501
5 Total number of participants at the beginning of the plan year	**5**	338
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)**	338
a(2) Total number of active participants at the end of the plan year	**6a(2)**	326
b Retired or separated participants receiving benefits	**6b**	1
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	327
e 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 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 4D 4E 4F

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[ ] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[X] Trust	**(3)**	[X] Trust
(4)	[ ] General assets of the sponsor	**(4)**	[ ] General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [ ] 0 **A** (Insurance Information)
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(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.) ..... ☐ Yes ☒ No

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.) ..... ☐ Yes ☐ No

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 C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2014** **This Form is Open to Public Inspection.**

For calendar plan year 2014 or fiscal plan year beginning 11/01/2014 and ending 10/31/2015

A Name of plan
TEAM EMPLOYEES HEALTH AND WELFARE TRUST FUND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TEAM RISK MANAGEMENT STRATEGIES LLC

D Employer Identification Number (EIN)
68-0535627

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(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)

HEALTHCOMP

621 SANTA FE AVENUE
FRESNO, CA 93721

77-0385729

(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 13 50	NONE	176630	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

BLUE SHIELD

94-0360524

(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?
50 99	NONE	98238	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

BENEFIT HEALTH ADVISOR

84-1095660

(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?
22 50	NONE	35874	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

DISCOVERY BENEFIT SOLUTIONS

80-0290814

(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?
22 50	NONE	24084	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

GALLAGHER BENEFIT SERVICES

36-4291971

(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?
22 50	NONE	11574	Yes [ ] No [X]	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 [ ]

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
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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) Enter 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) Enter 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

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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

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

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

For calendar plan year 2014 or fiscal plan year beginning 11/01/2014 and ending 10/31/2015

A Name of plan
TEAM EMPLOYEES HEALTH AND WELFARE TRUST FUND WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TEAM RISK MANAGEMENT STRATEGIES LLC

D Employer Identification Number (EIN)
68-0535627

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	76427	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	174569	44655
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	250996	44655
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	0	5589
k Total liabilities (add all amounts in lines 1g through1j)	1k	0	5589
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	250996	39066

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	2952564	
(B) Participants	2a(1)(B)	924353	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		3876917
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		0
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		42433
d Total income. Add all **income** amounts in column (b) and enter total	2d		3919350
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	3197080	
(2) To insurance carriers for the provision of benefits	2e(2)	561056	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		3758136
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)	47374	
(2) Contract administrator fees	2i(2)	290090	
(3) Investment advisory and management fees	2i(3)	0	
(4) Other	2i(4)	35680	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		373144
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		4131280
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-211930
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [X] Unqualified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [ ] Yes [X] No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: DIEM CPA, INC. **(2)** EIN: 20-4025501

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	

			Yes	No	Amount
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i		X	
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?
If "Yes," enter the amount of any plan assets that reverted to the employer this year..... ☐ **Yes** ☒ **No** **Amount:**

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ..... ☐ Yes ☐ No ☐ Not determined

Part V Trust Information (optional)

6a Name of trust	**6b** Trust's EIN
TEAM EMPLOYEES HEALTH AND WELFARE TRUST	466299079

TEAM Employees Health and Welfare Trust Fund
Welfare Benefit Plan
Financial Statements and Independent Auditor's Report
October 31, 2015 and 2014

TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan
Financial Statements
October 31, 2015 and 2014

Table of Contents

	Page
Independent Auditor's Report	1
Financial Statements	
Statements of Net Assets Available for Benefits	2
Statements of Changes in Net Assets Available for Benefits	3
Notes to Financial Statements	4-7

Note: All schedules required by Section 2520.103-10 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.

DIEM CPA, INC.

CERTIFIED PUBLIC ACCOUNTANT

2828 Cochran Street, #367, Simi Valley, CA 93065 (805)522-8827

Independent Auditor's Report
Members of the Board of Trustees and Participants
TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan
La Mesa, California

Report on the Financial Statements

I have audited the accompanying financial statements of the TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan, which comprise the statements of net assets available for benefits as of October 31, 2015 and 2014, and the related statement of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that I plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the plan's internal control. Accordingly, I express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements referred to above present fairly, in all material respects, the status of TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan as of October 31, 2015, and the changes in its financial status for the year then ended, in accordance with accounting principles generally accepted in the United States of America.

Other Matter

The financial statements of TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan as of October 31, 2014, were audited by another auditor who expressed an unmodified opinion on those statements on March 31, 2015.



Simi Valley, California
February 25, 2016

TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan
Statements of Net Assets Available for Benefits
October 31, 2015 and 2014

	2015	2014
Assets		
Cash	$ -	$ 76,427
Stop-loss insurance reimbursements receivable	44,655	174,569
Total Assets	44,655	250,996
Liabilities		
Accounts payable	(5,589)	-
Net Assets Available For Benefits	$ 39,066	$ 250,996

The Accompanying Notes are an Integral Part of These Financial Statements

TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan
Statements of Changes in Net Assets Available for Benefits
October 31, 2015 and 2014

	2015	2014
Additions To Net Assets Attributable To:		
Contributions		
Employer contributions	$ 2,952,564	$ 2,394,405
Participant contributions	924,353	892,565
Other income	42,433	26,377
Total Additions	3,919,350	3,313,347
Deductions From Net Assets Attributable To:		
Benefits paid to participants	3,197,080	2,556,368
Premiums paid for stop-loss insurance coverage	561,056	550,648
Administrative expenses	373,144	293,954
Total Deductions	4,131,280	3,400,970
Net Decrease	(211,930)	(87,623)
Net Assets Available for Benefits, Beginning of Year	250,996	338,619
Net Assets Available for Benefits, End of Year	$ 39,066	$ 250,996

The Accompanying Notes are an Integral Part of These Financial Statements

Note 1 – Description of the Plan

The following description of the TEAM Employees Health and Welfare Trust Fund Welfare Benefit Plan (the "Plan") is provided for general information purposes only. Participants should refer to the plan document for a more complete description of the Plan's provisions, copies of which may be obtained from the Plan sponsor.

General

The Plan is a defined benefit health and welfare plan covering all active full-time employees of TEAM Risk Management Strategies, LLC (the "Company") who have completed 60 days of services, as defined, and their covered dependents. The Plan was established on November 1, 2012. The Plan's assets are held in a Voluntary Employee Benefit Association (VEBA trust). The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

Contributions

The Company contributes, on an as-needed basis, amounts that are sufficient to enable the Plan to pay claims, stop-loss insurance premiums, and administrative expense. Any deficiency of the Plan's net assets over benefit obligations is funded by the Company on a pay-as-you-go basis. Participants contribute specified amounts to the Plan based on applicable monthly premiums for their respective benefit elections.

Benefits

The Plan provides self-funded medical, dental and vision benefits to eligible employees who have elected to participate in the Plan and their covered dependents. The Plan also offers continuation of benefits upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

The Plan has entered into a stop-loss insurance arrangement to limit its exposure to self-funded medical benefits. The specific stop-loss coverages reimburses the Plan for eligible claim expenses paid by the Plan in excess of $80,000 per individual per year. The aggregate stop-loss coverage reimburses the Plan for eligible claims expenses paid by the Plan in access of an annual aggregate deductible. The maximum reimbursement payable to the Plan under the aggregate stop-loss coverage is $1,000,000 per year.

All other Plan benefits are self-insured. Claims for self-funded benefits are processed by third-party claims processors under administrative services only ("ASO") arrangements. The claims processors pay claims from funds provided by the Plan. Despite the Plan's utilization of third-party claims processors, the ultimate responsibility for the payment of claims is retained by the Plan.

Plan obligations for claims incurred but not reported ("IBNR") are estimated by the Plan's management, based on historical claims data provided by the Plan's third-party claims administrators.

Note 2 – Significant Accounting Policies

Basis of Accounting

The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. These financial statements were approved by the trustees of the Plan and available for issuance on February 25, 2016. Subsequent events have been evaluated through this date.

Use of Estimates

The preparation of financial statements, in conformity with accounting principles generally accepted in the United States of America, requires the Plan's management to make estimates and assumptions that affect the reported amounts of net assets available for benefits and changes therein. Actual results could differ from those estimates.

Payment of Benefits

Benefit payments to participants are recorded when paid by the third-party claims processor. Benefits are reported net of related stop-loss insurance reimbursements. During the years ended October 31, 2015 and 2014, stop-loss insurance reimbursements totaling $1,172,054 and $585,147, respectively, have been netted with claims paid in the accompanying statements of changes in net assets.

Stop-Loss Insurance Reimbursements Receivable

Stop-loss insurance reimbursement receivable is recorded when claims are paid at the amount expected to be received from the insurer. An allowance for uncollectible receivables may be recorded based on management's review of outstanding amounts. Stop-loss insurance reimbursements receivable are estimated to be fully collectible at October 31, 2015 and 2014.

Premiums Paid for Stop-Loss Insurance Coverage

Premiums paid for stop-loss insurance coverage are recorded ratably over the policy period.

Administrative Expenses

Administrative expenses of the Plan may be paid by the Plan as provided in the Plan document. However, the Company may also pay the Plan expenses directly. Transaction charges for loan and benefit payment transactions, if any, are paid by the Plan by reducing the balances of those participants initiating the transaction.

Note 3 – Federal Income Tax Status

The Internal Revenue Service has determined and informed the Company, via a letter dated April 21, 2013, that the Plan is qualified and the trust established under the Plan is tax-exempt, under the appropriate sections of the Internal Revenue Code section 501(c)(9). The Plan has been amended since receiving the determination letter, however, the Plan administrator and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

Note 3 – Federal Income Tax Status (continued)

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain tax position that, more likely than not, would not be sustained upon examination by the Internal Revenue Service. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of October 31, 2015 and 2014, there were no uncertain positions taken, or expected to be taken, that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing authorities and other jurisdictions, however, there are currently no audits in progress for any tax periods. The plan administrator believes it is no longer subject to income tax examinations on tax returns filed prior to 2011.

Note 4 – Benefit Obligation

	Stop-Loss Insurance Premiums Payable	Claims Payable, Including IBNR	Stop-Loss Insurance Recoveries Receivable	Total
Balance, November 1, 2013	$ -	$ 362,418	$ (327,915)	$ 34,503
Premiums incurred	550,648	-	-	550,648
Premiums paid	(550,648)	-	-	(550,648)
Change in estimate	-	1,480	-	1,480
Claims incurred, net	-	3,597,763	(740,802)	2,856,961
Claims paid, net	-	(3,141,514)	585,146	(2,556,368)
Balance October 31, 2014	-	820,147	(483,571)	336,576
Premiums incurred	561,056	-	-	561,056
Premiums paid	(561,056)	-	-	(561,056)
Claims incurred, net	-	4,157,940	(868,273)	3,289,667
Claims paid, net	-	(4,369,134)	1,172,054	(3,197,080)
Balance October 31, 2015	$ -	$ 608,953	$ (179,790)	$ 429,163

Claims payable, including IBNR, includes (1) all reported claims incurred during the year which were unpaid as of year-end and, (2) management's estimate of claims incurred but not reported (IBNR).

Note 5 – Party-In-Interest Transactions

Parties-in-interest are defined under Department of Labor regulations as any fiduciary of the Plan, any party rendering service to the Plan, the employer, and certain others. As discussed in Note 1, the third-party claims processors are parties in interest to the Plan.

Note 6 – Plan Termination

Although it has not expressed any intent to do so, the Company has the right under the Plan to modify the benefits provided to, and contributions required of, participants, to discontinue its contributions to the Plan, and to terminate the Plan subject to the provisions set forth in ERISA. Upon termination, all of the Plan's assets will be applied in a uniform and nondiscriminatory manner toward the provision of benefits to the participants and to pay administrative expenses. No assets of the Plan may revert to the Company or be used for purposes other than for the exclusive benefit of the Plan's participants.