Form 5500	Annual Return/Report of Employee Benefit Plan			OMB Nos. 12 12	10-0110 10-0089
Department of the Treasury Internal Revenue Service Department of Labor	and 4065 of the Employee Retirement	nployee benefit plans under sections 104 Income Security Act of 1974 (ERISA) and ) of the Internal Revenue Code (the Code).			
Employee Benefits Security Administration		ries in accordance with		2015	
Pension Benefit Guaranty Corporation		s to the Form 5500.			
		This	Form is Open to Pu Inspection	blic	
	ntification Information				
For calendar plan year 2015 or fiscal	plan year beginning 04/01/2015	and ending 03/31/20	)16		
A This return/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking the participating employer information in accord			ns); or
	X a single-employer plan;	a DFE (specify)			
<b>B</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).			
<b>C</b> If the plan is a collectively-bargain	ed plan, check here			•	
<b>D</b> Check box if filing under:	Form 5558;	automatic extension;	the	e DFVC program;	
	special extension (enter description)	1			
Part II Basic Plan Inform	mation—enter all requested informatior	า			
<b>1a</b> Name of plan CHILDERS OIL GROUP BENEFITS			1b	Three-digit plan number (PN) ▶	503
			1c	Effective date of pla 04/01/2015	an
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)		foreign, see instructions)	2b Employer Identification Number (EIN) 61-0702219		
CHILDERS OIL CO., INC.			2c	Plan Sponsor's tele number 606-633-2525	
P.O. BOX 430 51 HIGHWAY 2034 WHITESBURG, KY 41858-7686	P.O. BOX 430 51 HIGHWAY 2034 WHITESBURG, KY 41858-7686		2d	Business code (see instructions) 423990	)

## 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	Filed with authorized/valid electronic signature.	10/31/2016	TERRY ANDERSON					
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan	administrator				
SIGN HERE	Filed with authorized/valid electronic signature.	10/31/2016	3 TERRY ANDERSON					
	Signature of employer/plan sponsor	Date	Enter name of individual signing as empl	oyer or plan sponsor				
SIGN HERE								
	Signature of DFE	Date	Enter name of individual signing as DFE					
Preparei	's name (including firm name, if applicable) and address (include r	room or suite numbe	r) Preparer's telepl	hone number				
TERRY	C. ANDERSON	600	6-633-2525					
51 HIGHWAY 2034 WHITESBURG, KY 41858								
For Pap	For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.							

Page **2** 

3a	Plan administrator's name and address XSame as Plan Sponsor	<b>3b</b> 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,	4b EIN	4	
-	EIN and the plan number from the last return/report:		- 	
а	Sponsor's name	4C PN		
5	Total number of participants at the beginning of the plan year	5	139	
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).			
<b>a(</b> 1	) Total number of active participants at the beginning of the plan year	6a(1)	139	
a(2	2) Total number of active participants at the end of the plan year	. 6a(2)	142	
b	Retired or separated participants receiving benefits	. 6b	0	
С	Other retired or separated participants entitled to future benefits	. 6c	0	
d	Subtotal. Add lines 6a(2), 6b, and 6c.	. 6d	142	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e		
f	Total. Add lines 6d and 6e	. 6f	142	
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 Code	es 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

9a	9a Plan funding arrangement (check all that apply)			<b>9b</b> Plan benefit arrangement (check all that apply)				
	(1)	X	Insurance		(1)	X		Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)			Code section 412(e)(3) insurance contracts
	(3)		Trust		(3)			Trust
	(4)	X	General assets of the sponsor		(4)	X		General 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)							
a Pension Schedules			b General Schedules					
	(1)		R (Retirement Plan Information)		(1)		]	H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)			I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X		_7 A (Insurance Information)
			actuary		(4)	Х		C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			<b>D</b> (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)			<b>G</b> (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.)				
<b>11b</b> Is the plan	currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)			
<b>11c</b> Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 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.)				

	SCHEDULE A Insurance Information			ОМ	B No. 1210-0110		
Department of the Treas Internal Revenue Servi	sury	This schedule is required Employee Retirement Inc					2015
Department of Labor Employee Benefits Security Ad	r		ttachment to Form 55		)-		2013
Pension Benefit Guaranty Co		Insurance companies a		he informa	ion		m is Open to Public Inspection
For calendar plan year 20	15 or fiscal plar	•		and er	iding 03/3	31/2016	
A Name of plan CHILDERS OIL GROUP I	BENEFITS				e-digit number (P	N) 🕨	503
C Plan sponsor's name a CHILDERS OIL CO., INC.		e 2a of Form 5500			oyer Identific 0702219	ation Number (	EIN)
Part I Information on a separat	on Concern e Schedule A.	ing Insurance Contract C Individual contracts grouped as a	Coverage, Fees, a a unit in Parts II and III	nd Com	missions	Provide inform	ation for each contract A.
1 Coverage Information:							
(a) Name of insurance ca ANTHEM LIFE INSURANC							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
35-0980405	61069	00235242	138	3	04/01/201	5	03/31/2016
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,	brokers, and of	her persons in
(a) Total a	amount of comr			<b>(b)</b> To	otal amount	of fees paid	
		640					
3 Persons receiving com		ees. (Complete as many entries a					
COMPREHENSIVE BUSIN				m commiss	ions or fees	were paid	
	. d b a s a	Fee	s and other commission	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpose				(e) Organization code
	533						
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
ARCORP LLC		333 W. STE 16	VINE STREET				
(b) Amount of color or	nd base	Fee	s and other commission	ns paid			
(b) Amount of sales and base commissions paid     rees and other commissions paid       107     107			(e) Organization code				
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for F	Form 5500.		Scheo	lule A (Form 5500) 2015 v. 150123

## (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	<ul> <li>(e) Organization code</li> </ul>		
(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	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	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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

P	art I	I Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contract	s with each carrier ma	v he treated	as a unit for purposes of
		this report.				
4		rent value of plan's interest under this contract in the general account at year			. 4	
5		rent value of plan's interest under this contract in separate accounts at year e	nd			
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	С	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in con- retention of the contract or policy, enter amount			. 6d	
		Specify nature of costs				
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck 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	ate participatio	on 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				
		(4) Transferred from separate account				
		(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:	- (1)			
		(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) 7e(4)			
		(4) Other (specify below)				
		•				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f	

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Pa	art III	Welfare Benefit Contract Information	tion						
		If more than one contract covers the same g information may be combined for reporting p							
		the entire group of such individual contracts						JIS COV	er individual employees,
8	Bene	fit and contract type (check all applicable boxes)							
	a	Health (other than dental or vision)	b	Dental	с	Vision		d 🗙	Life insurance
	еГ	Temporary disability (accident and sickness)	f	Long-term disabili	ty <b>g</b>	Supplemental unen	nployment	h∏	Prescription drug
	iΓ	Stop loss (large deductible)	iП	HMO contract	k	PPO contract		ıΠ	Indemnity contract
	m	Other (specify)	• 🗆		L	_			
	···· L								
9	Expe	rience-rated contracts:							
	<b>a</b> P	remiums: (1) Amount received			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 ( <b>(1) + (2) - (3)</b> )					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	on an a	accrual basis)					
		(A) Commissions			9c(1)(A)				
		(B) Administrative service or other fees			9c(1)(B)				
		(C) Other specific acquisition costs			9c(1)(C)				
		(D) Other expenses			9c(1)(D)				
		(E) Taxes			9c(1)(E)				
		(F) Charges for risks or other contingencies.			9c(1)(F)				
		(G) Other retention charges			9c(1)(G)				
		(H) Total retention					9c(1)(H	)	
		(2) Dividends or retroactive rate refunds. (These	e amou	ints were paid ir	cash, or	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (1							
		(2) Claim reserves							
		(3) Other reserves							
	е	Dividends or retroactive rate refunds due. (Do n	ot inclu	ude amount entered	d in line 9c(2	<b>)</b> .)			
10		experience-rated contracts:							
		Total premiums or subscription charges paid to o	carrier				10a		4288
	-	If the carrier, service, or other organization incur							
		retention of the contract or policy, other than rep					<b>10b</b>		

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	× No	
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insurar	nce Informatio	n				
(Form 5500		moulai				OM	B No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury		red to be filed under section 104 of the Income Security Act of 1974 (ERISA).			2015		
	Department of Labor Employee Benefits Security Administration			00.				
			are required to provide t ERISA section 103(a)(2)		tion		This Form is Open to Public Inspection	
For calendar plan year 20	For calendar plan year 2015 or fiscal plan year beginning 04/01/20			and er	nding 03/3	31/2016		
A Name of plan CHILDERS OIL GROUP	BENEFITS				e-digit number (P	N) ►	503	
C Plan sponsor's name a CHILDERS OIL CO., INC		∋ 2a of Form 5500		-	oyer Identific	cation Number (	EIN)	
		ing Insurance Contract Individual contracts grouped as						
<b>1</b> Coverage Information:								
(a) Name of insurance ca ANTHEM HEALTH PLANS		Y, INC.						
	(c) NAIC	(d) Contract or	d) Contract or (e) Approximate nu			Policy or contract year		
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To	
61-1237516	95120	001008834	108	}	01/01/201	6	03/31/2016	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	amount of comr			<b>(b)</b> T	otal amount	of fees paid		
		330						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).				
COMPREHENSIVE BUSIN		nd address of the agent, broker		m commiss	sions or fees	s were paid		
COMPREHENSIVE BUSIN	NESS INS. SOL		30X 1485 3IN, KY 40702					
(b) Amount of sales ar	nd base	Fe	Fees and other commissions paid					
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code	
	330							
	(a) Name a	nd address of the agent, broker	r, or other person to who	m commiss	sions or fees	s were paid		
		 Fe	es and other commissio	ns paid				
(b) Amount of sales an commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code	

For Paperwork Reduction Act Notice 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) Nan	me and address of the agent, broke	r, 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	Fees and other commissions paid							
commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
(a) Na	(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

P	art I	I Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contract	s with each carrier ma	v he treated	as a unit for purposes of
		this report.				
4		rent value of plan's interest under this contract in the general account at year			. 4	
5		rent value of plan's interest under this contract in separate accounts at year e	nd			
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	С	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in con- retention of the contract or policy, enter amount			. 6d	
		Specify nature of costs				
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here		
7	Con	ntracts 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	ate participatio	on 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				
		(4) Transferred from separate account				
		(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:	- (1)			
		(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) 7e(4)			
		(4) Other (specify below)				
		•				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f	

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Part I	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 s ourposes if such contracts with each carrier may be t	are experien	ce-rated as a unit. V	Vhere contrac	
8 Ber	nefit 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 Long-term disabilit	ty <b>g</b>	Supplemental une	mployment	h Prescription drug
i	Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
m			L	-		
<b>9</b> Exp	perience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			_
	(3) Increase (decrease) in unearned premium re	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))					
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (	on an accrual basis)				_
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		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					
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention					
	(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in	cash, or	credited.)	····· 9c(2)	
d	Status of policyholder reserves at end of year: (	1) Amount held to provide	benefits after	r retirement	9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
е	Dividends or retroactive rate refunds due. (Do r	not include amount entered	d in line <b>9c(2</b> )	.)	9e	
10 N	onexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier			10a	33
b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	rred any specific costs in c	onnection wi	th the acquisition or		
-						

Specify nature of costs 🕨

Part I	Provision of Information			
<b>11</b> Dia	the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
<b>12</b> If t	e answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Information	n		OM	B No. 1210-0110
(Form 5500)	-				-		
Department of the Trease Internal Revenue Service		This schedule is required Employee Retirement Inc					2015
Department of Labor Employee Benefits Security Adn		File as an at	tachment to Form 55	00.	-		
Pension Benefit Guaranty Cor	rporation	<ul> <li>Insurance companies as pursuant to E</li> </ul>	re required to provide tl RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
	15 or fiscal plar	n year beginning 04/01/2015		and er	ding 03/31/	/2016	•
A Name of plan CHILDERS OIL GROUP E	BENEFITS			B Thre plan	e-digit number (PN)	•	503
C Plan sponsor's name as CHILDERS OIL CO., INC.		e 2a of Form 5500			oyer Identificat 0702219	tion Number (	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:		0		·		<u>.</u>	
(a) Name of insurance car HARTFORD LIFE AND ACC							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) F	rom	<b>(g)</b> To
06-0838648	70815	875936G	189		04/01/2015		03/31/2016
2 Insurance fee and comm descending order of the		ation. Enter the total fees and tota	l commissions paid. Li	ist in line 3	the agents, b	rokers, and o	ther persons in
0	amount of com	missions paid		<b>(b)</b> To	otal amount of	fees paid	
		2203482					871944
3 Persons receiving comr	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	<b>(a)</b> Name a	and address of the agent, broker, o		m commiss	ions or fees w	vere paid	
LESLIE FEATHERLY			NNINGDALE DR. ETOWN, KY 40324				
(b) Amount of sales an	nd base	Fees	s and other commissior	ns paid			1
commissions paid	d 1101741	(c) Amount		(d) Purpose			(e) Organization code
	1101741						3
	(a) Name a	and address of the agent, broker, o	or other person to whor	m commiss	ions or fees w	vere paid	·
		P.O. BC	X 106				
THE HINTON AGENCY, LL	_C		IGSBURT, KY 41041				
THE HINTON AGENCY, LL	_C	FLEMIN					1
(b) Amount of sales an	nd base	FLEMIN	s and other commissior				
	nd base —	FLEMIN Fee: (c) Amount	s and other commissior	ns paid <b>(d)</b> Purpos	e		(e) Organization code
<b>(b)</b> Amount of sales an	nd base	FLEMIN Fee: (c) Amount	s and other commission		e		

## (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	me and address of the agent, broke	r, 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	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		(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

P	art I	I Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contract	s with each carrier ma	v he treated	as a unit for purposes of
		this report.				
4		rent value of plan's interest under this contract in the general account at year			. 4	
5		rent value of plan's interest under this contract in separate accounts at year e	nd			
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	С	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			. 6d	
		Specify nature of costs				
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here		
7	Con	ntracts 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	ate participatio	on 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				
		(4) Transferred from separate account				
		(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:	- (1)			
		(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) 7e(4)			
		(4) Other (specify below)				
		•				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f	

Page	4
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Pa	rt II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu	urposes if such contracts a	are experienc	e-rated as a unit. Wh	nere contract	
_	_	the entire group of such individual contracts w	with each carrier may be to	reated as a u	nit for purposes of this	s report.	
8	Bene	efit and contract type (check all applicable boxes)	. —		1		. —
	a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> 🗙 Life insurance
	е	Temporary disability (accident and sickness)	f 🛛 Long-term disabilit	у <b>д</b>	Supplemental unem	ployment	<b>h</b> Prescription drug
	i [	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify) ACCIDENT AND DISABILIT	Y, SHORT TERM DISABI	LITY			
	L						
9	Expe	rience-rated contracts:					
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	1	9a(2)			]
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))					
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))					
		(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)			4
		(E) Taxes					4
		(F) Charges for risks or other contingencies					_
		(G) Other retention charges				0=(1)(1)	
		(H) Total retention	—			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1	, 1				
		(2) Claim reserves					
	•	(3) Other reserves					
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	i in line 9C(2).	.)	<b>9e</b>	
10		nexperience-rated contracts:	orrior			100	4404
	-	Total premiums or subscription charges paid to c				10a	1101
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo					

Specify nature of costs

Part IV	Provision of Information			
11 Did t	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuran	ce Informatio	n		OM	B No. 1210-0110
(Form 5500			· · · · · · ·				
Department of the Treas Internal Revenue Serv		This schedule is required Employee Retirement In					2015
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)		tion	This For	m is Open to Public Inspection
For calendar plan year 20	15 or fiscal plar	year beginning 04/01/2015		and er	nding 03/3	31/2016	•
A Name of plan CHILDERS OIL GROUP	BENEFITS			-	e-digit number (P	N) ►	503
C Plan sponsor's name a CHILDERS OIL CO., INC		e 2a of Form 5500			oyer Identific 0702219	cation Number (	EIN)
		ing Insurance Contract Individual contracts grouped as					
<b>1</b> Coverage Information:		¥ :					
(a) Name of insurance ca COLONIAL LIFE & ACCID		CE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
57-0144607	62049	E3888807	115 04/01/201		5	03/31/2016	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
	amount of comr	nissions paid		<b>(b)</b> T	otal amount	of fees paid	
		2240					214
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
LESLIE ANN FEATHERLY		nd address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid	
			GETOWN, KY 40324				
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount	(d) Purpose			(e) Organization code	
	751	38 U	NKNOWN				3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid	I
NORMA J. DAVIS			JFFIAN TRAIL IN, KY 40701				
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code
	31	24 U	NKNOWN				3
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	e the instructions for F	Form 5500		Schee	ule A (Form 5500) 2015 v. 150123

	me and address of the execut brake	r or other person to whom commissions or foco were point	4		
		r, or other person to whom commissions or fees were pai	ld		
MARY DUFF	MARY DUFF 176 PASADENA DRIVE LEXINGTON, KY 40503				
			Т		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
61			3		
			÷		
		r, or other person to whom commissions or fees were pai	d		
DEE ANN SLADE		OTOMAC COURT			
	FRAN	IKFORT, KY 40601			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
	3	UNKNOWN	3		
	<b>°</b>		Ŭ		
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	d		
SARAH BARDELL		CRUSADERS WAY			
	LEXIN	NGTON, KY 40509			
		Fees and other commissions paid			
(b) Amount of sales and base	(c) Amount	(d) Purpose	(e) Organization		
commissions paid	<b>(C)</b> Amount 63	UNKNOWN	code		
137	03	UNKNOWN	3		
(a) Na	me and address of the agent broke	r, or other person to whom commissions or fees were pai	d		
VANCE NEAL MICHAEL		ASADENA DRIVE			
		NGTON, KY 40503			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
77			3		
	and a delegation of the second states				
		r, or other person to whom commissions or fees were pai	d		
LISA R GRAVES					
	FRAN	IKFORT, KY 40601			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
23			3		

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Schedule A (Form 5500) 2	2015	Page <b>2 -</b> 2	
(a) Nan	he and address of the agent br	oker, or other person to whom commissions or fees were p	aid
BOBBIE J. WHITTAKER	25	30 SCOTTSVILLE ROAD DLLING GREEN, KY 42104	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
5			3
		oker, or other person to whom commissions or fees were p	aid
ANNE OWENS		16 DEAR LAKE DRIVE XINGTON, KY 40515	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
9			3
(a) Nan	ne and address of the agent, bro	bker, or other person to whom commissions or fees were p	aid
BART GAUNT		21 ST GERMAINE CT DUISVILLE, KY 40207	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
5		6 UNKNOWN	3
(a) Nan	ne and address of the agent, bro	bker, or other person to whom commissions or fees were p	aid
DANNY KYLE PRATER		O. BOX 601 NINTSVILLE, KY 41240	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
21		2 UNKNOWN	3
(a) Nan	ne and address of the agent, bro	oker, or other person to whom commissions or fees were p	aid
IELISSA ANN HINTON		1 EAST ELECTRIC AVENUE EMINGSBURG, KY 41041	
(b) Amount of solar and have		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code

5 UNKNOWN

3

Schedule A (	Form	5500	2015

(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pair	ł
AMY BOWMAN	6214 \$	SULPHUR WELL DLASVILLE, KY 40356	~
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
140	45	UNKNOWN	3
(a) Na THE HINTON AGENCY, LLC	P.O. E	r, or other person to whom commissions or fees were pair 3OX 106 INGSBURG, KY 41041	
(b) Amount of sales and base commissions paid	( <b>c)</b> Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na EMPLOYEE BENEFIT SOLUTIONS, (b) Amount of sales and base	LLC 2785 I BENT	r, or other person to whom commissions or fees were pair MAYFIELD HIGHWAY ON, KY 42025 Fees and other commissions paid	(e) Organization
commissions paid 71	<b>(c)</b> Amount 24	(d) Purpose	code 3
(a) Na VICKIE E. LEWIS	6558 \$	r, or other person to whom commissions or fees were pair STOVALL RD CITY, KY 42127	3
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 97	(c) Amount 20	(d) Purpose	code 3
(a) Na KATHERINE MCCORMICK	P.O. E	r, or other person to whom commissions or fees were pair 3OX 95 3AR, WV 25064	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid	(e) Organization
commissions paid 216	( <b>c)</b> Amount 0	(d) Purpose	code 3

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

# MOUNTAIN STATE EMPLOYEE BENEFITS

103 6TH AVE ST ALBANS, WV 25064

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount (d) Purpose		code	
32	5	UNKNOWN	3	
(a) Name	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	aid	
REGINA SCHMUTTE		HARWOOD DR. NGTON, KY 40515		
(b) Amount of sales and base	Fees and other commissions paid		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
46	7	UNKNOWN	3	
(a) Name	and address of the agent broke	r, or other person to whom commissions or fees were pa	aid	

(b) Amount of sales and base Fees and other commissions paid (e) Organization and a grade for the sales and base (e) Organization and a grade for the sales and the sales

(D) Amount of sales and base					
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		(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

P	art I	I Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contract	s with each carrier ma	v he treated	as a unit for purposes of
		this report.				
4		rent value of plan's interest under this contract in the general account at year			. 4	
5		rent value of plan's interest under this contract in separate accounts at year e	nd			
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	С	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			. 6d	
		Specify nature of costs				
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here		
7	Con	ntracts 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	ate participatio	on 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				
		(4) Transferred from separate account				
		(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:	- (1)			
		(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) 7e(4)			
		(4) Other (specify below)				
		•				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f	

		Schedule A (Form 5500) 2015		Page <b>4</b>	
Pa	rt 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 e	experience-rated as a unit. Where contra	
8	a      e    <sup>-</sup> i    :	and contract type (check all applicable boxes) Health (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify)	<ul> <li>b Dental</li> <li>f Long-term disability</li> <li>j HMO contract</li> </ul>	C ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d X Life insurance h ☐ Prescription drug I ☐ Indemnity contract
9	<b>a</b> Pre	ence-rated contracts: emiums: (1) Amount received		a(1)	_

а	Premiums: (1) Amount received	9a(1)			
	(2) Increase (decrease) in amount due but unpaid	9a(2)			
	(3) Increase (decrease) in unearned premium reserve	9a(3)			
	(4) Earned ((1) + (2) - (3))	-		. 9a(4)	 
b					
	(2) Increase (decrease) in claim reserves				
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )			. 9b(3)	 
	(4) Claims charged			. 9b(4)	 
С	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees				
	(C) Other specific acquisition costs	a (1)(a)			
	(D) Other expenses	9c(1)(D)			
	(E) Taxes				
	(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	in cash. or	credited.)		
d					 
	(2) Claim reserves			. 9d(2)	 
	(3) Other reserves				 
е					 
	Vonexperience-rated contracts:		<b>,</b> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
a				. 10a	57775
b					 51115
N	retention of the contract or policy, other than reported in Part I, line 2 ab		•	. 10b	0
		,		L	 

Specify nature of costs

Part IV Provision of Information

	11	Did the insurance company fail to provide any information necessary to complete Schedule A?	X	Yes	No	
	12	If the answer to line 11 is "Yes," specify the information not provided.				
T١	/PE	OF INSURANCE POLICY SOLD, EXPLANATION OF FEES CHARGED				

SCHEDUL (Form 55		Insurance Information			OMB No. 1210-0110		
Department of the T Internal Revenue S	reasury	This schedule is required					2015
Department of L Employee Benefits Security	abor	Employee Retirement Inc	ttachment to Form 550		).		2013
Pension Benefit Guaranty	re required to provide th RISA section 103(a)(2).	ne informa	ion –	This Fo	rm is Open to Public Inspection		
	2015 or fiscal pla	n year beginning 04/01/2015	I	and er	ding 03/31/	2016	
A Name of plan CHILDERS OIL GROU	IP BENEFITS		-	B Thre	e-digit number (PN)	•	503
C Plan sponsor's nam CHILDERS OIL CO., IN		e 2a of Form 5500		•	oyer Identificat 0702219	ion Number	(EIN)
		ing Insurance Contract ( Individual contracts grouped as a					
1 Coverage Information	n:						
(a) Name of insurance COLONIAL LIFE & ACC		ICE COMPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			,	contract year
(4) =	code	identification number	policy or contract		(f) F	rom	<b>(g)</b> To
57-0144607	62049	E4038469	28		04/01/2015	03/31/2016	
2 Insurance fee and co descending order of		ation. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents, br	okers, and o	other persons in
v	al amount of com			<b>(b)</b> To	otal amount of	fees paid	
		7697					665
3 Persons receiving c		ees. (Complete as many entries		,			
THE HINTON AGENCY		ind address of the agent, broker, P.O. BC		n commiss	ions or fees w	vere paid	
	, ===		IGSBURG, KY 41041				
(b) Amount of sales	and base	Fee	s and other commission	is paid			
commissions		(c) Amount		d) Purpos	e		(e) Organization code
	44						3
	(a) Name a	ind address of the agent, broker,	or other person to whon	n commiss	ions or fees w	vere paid	
EMPLOYEE BENEFIT	<u> </u>	2785 M	AYFIELD HIGHWAY N, KY 42025				
	and here	Fee	s and other commission	is paid			
(b) Amount of sales and base commissions paid		(c) Amount	(d) Purpose			(e) Organization code	
	267	92 UI	NKNOWN				3
For Paperwork Reduc	tion Act Notice a	Ind OMB Control Numbers, see	the instructions for F	orm 5500.		Sche	dule A (Form 5500) 2015 v. 150123

# (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid LESLIE ANN FEATHERLY 134 SUNNINGDALE DRIVE GEORGETOWN, KY 40324

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
2312	116	UNKNOWN	3	
(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	l	
NORMA J. DAVIS		UFFIAN TRAIL BIN, KY 40701		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
54	23	UNKNOWN	3	
(a) Nar		r, or other person to whom commissions or fees were pa	id	
	LOUI	SVILLE, KY 40245		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid 328	(c) Amount	(d) Purpose	code 3	
( <b>a)</b> Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	id	
MARY DUFF		ASADENA DRIVE IGTON, KY 40503		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
398	24	UNKNOWN	3	
(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	id	
DEE ANN SLADE		OTOMAC COURT IKFORT, KY 40601		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
380	18	UNKNOWN	3	

	20.0	- ~go =	
( <b>2</b> ) No	ma and address of the agent, broke	r or other person to whom commissions or fees were pa	
SARA BARDELL		r, or other person to whom commissions or fees were pai CRUSADERS WAY	u
		IGTON, KY 40509	
	1		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
244	112	UNKNOWN	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	d
VANCE NEAL MICHAEL		ASADENA DRIVE	
	LEXIN	NGTON, KY 40503	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
166	20	UNKNOWN	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	d
LISA R. GRAVES		GLENNS CREEK ROAD	
	FRAN	IKFORT, KY 40601	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
108			3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	d
BOBBIE J. WHITTAKER		SCOTTSVILLE ROAD	
	BOM	LING GREEN, KY 42104	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
31	1	UNKNOWN	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	d
ANNE OWENS			
	LEXIN	NGTON, KY 40515	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
166			3

Schedule A (	Form	5500	) 2015

<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
BART GAUNT		ST GERMAINE CT SVILLE, KY 40207	
		SVILLE, RT 40207	
(h) Amount of color and baca		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
5	6	UNKNOWN	3
(a) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
ANDREW THOMAS DONOHOO		HADY LANE	
	MURE	RAY, KY 42071	
		Face and other commissions paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 326	(c) Amount	(d) Purpose	code 3
020			Ť
	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
DANNY KYLE PRATER		30X 601	<u>u</u>
Braatte Hereite Hottele		rsville, ky 41240	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
37	4	UNKNOWN	3
	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
MELISSA ANN HINTON		AST ELECTRIC AVENUE IINGSBURG, KY 41041	
(h) Amount of color and base			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
1861	17	UNKNOWN	3
	<u> </u>		
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
AMY BOWMAN	6214	SULPHUR WELL	<u></u>
	NICH	OLASVILLE, KY 40356	
	<u> </u>		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
543	201	UNKNOWN	3

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

SUZANNE BRATTON TUCKER	P.O. E LEXIN	P.O. BOX 22518 LEXINGTON, KY 40522			
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(e) Organization code			
122		(d) Purpose	3		
<b>(a)</b> Na		, or other person to whom commissions or fees were pa	id		
VICKIE LEWIS	6558 ( CAVE	STOVALL RD CITY, KY 42127			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
36			3		
( <b>a)</b> Na	me and address of the agent, broke	, or other person to whom commissions or fees were pa	id		
KATHERINE MCCORMICK		3OX 95 AR, WV 25064			
(b) Amount of sales and base	I	Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
81			3		
( <b>a)</b> Na	me and address of the agent, broke	, or other person to whom commissions or fees were pa	id		
MOUNTAIN STATE EMPLOYEE BEI		TH AVE BANS, WV 25177			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
12	2	UNKNOWN	3		
<b>(a)</b> Na	me and address of the agent, broke	, or other person to whom commissions or fees were pa	id		

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

P	art I	I Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contract	s with each carrier ma	v he treated	as a unit for purposes of
		this report.				
4		rent value of plan's interest under this contract in the general account at year			. 4	
5		rent value of plan's interest under this contract in separate accounts at year e	nd			
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	С	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			. 6d	
		Specify nature of costs				
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here		
7	Con	ntracts 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	ate participatio	on 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				
		(4) Transferred from separate account				
		(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:	- (1)			
		(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) 7e(4)			
		(4) Other (specify below)				
		•				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f	

гауе –
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Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts v					s cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)	nul each camer may be ut			Tepon.	
Ŭ	a	Health (other than dental or vision)	<b>b</b> Dental	<b>د</b> [	Vision		<b>d</b> X Life insurance
				c			
	е	Temporary disability (accident and sickness)	f Long-term disability	/ <b>g</b>	Supplemental unemp	oloyment	<b>h</b> Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m>	♦ Other (specify) ♦ OTHER UNKNOWN					
		_					
9	Expe	rience-rated contracts:	_				
	<b>a</b> F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	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)		1	
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o					_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C)			_
		(D) Other expenses		9c(1)(D)			4
		(E) Taxes		9c(1)(E)			4
		(F) Charges for risks or other contingencies		9c(1)(F)			4
		(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 o	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 9c(2).	.)	. 9e	
10		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c				10a	19086
	b	If the carrier, service, or other organization incurr				106	
		retention of the contract or policy, other than repo	nteu in Part I, line ∠ above	, тероп amo	uni	. 10b	

Part IV	Provision of Information		
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	X Yes	No
40			

**12** If the answer to line 11 is "Yes," specify the information not provided. TYPES OF INSURANCE POLICIES SOLD, EXPLANATION OF FEES CHARGED

Specify nature of costs

SCHEDULE	•	Incurence	e Informatio				
(Form 5500		insuranc	e mornatio	n		OM	IB No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required Employee Retirement Inc					2015
Department of Labor Employee Benefits Security Ad		File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	prporation	<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>			This Form is Open to Public Inspection		
For calendar plan year 207	15 or fiscal plan	year beginning 04/01/2015		and en	ding 03/3	1/2016	•
A Name of plan CHILDERS OIL GROUP I	BENEFITS			B Three plan	e-digit number (PN	J) 🕨	503
C Plan sponsor's name a CHILDERS OIL CO., INC.		2a of Form 5500			yer Identific 0702219	ation Number (	(EIN)
		ng Insurance Contract C ndividual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca COMPANION LIFE INSUR		NY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
			134	ŀ	04/01/2015	5	03/31/2016
2 Insurance fee and com descending order of the		ion. Enter the total fees and total	_				
descending order of the			_	ist in line 3		brokers, and o	
descending order of the	amount paid.		_	ist in line 3	the agents,	brokers, and o	
descending order of the (a) Total a	amount paid.		l commissions paid. L	ist in line 3 <b>(b)</b> To	the agents,	brokers, and o	
descending order of the (a) Total a	amount paid. amount of comm missions and fee	issions paid	I commissions paid. L	ist in line 3 (b) To persons).	the agents,	brokers, and o	
descending order of the (a) Total a	amount paid. amount of comm missions and fee	issions paid es. (Complete as many entries a	I commissions paid. L	ist in line 3 (b) To persons).	the agents,	brokers, and o	
descending order of the (a) Total a	amount paid. amount of comm missions and fee (a) Name an	issions paid es. (Complete as many entries a d address of the agent, broker, c	I commissions paid. L	ist in line 3 (b) To persons). m commiss	the agents,	brokers, and o	
descending order of the (a) Total a 3 Persons receiving com	amount paid. amount of comm missions and fee (a) Name an	issions paid es. (Complete as many entries a d address of the agent, broker, c	I commissions paid. L as needed to report all or other person to who s and other commission	ist in line 3 (b) To persons). m commiss	the agents, atal amount of	brokers, and o	
descending order of the (a) Total a 3 Persons receiving com (b) Amount of sales ar	amount paid. amount of comm missions and fee (a) Name an	issions paid es. (Complete as many entries a d address of the agent, broker, c Fees	I commissions paid. L as needed to report all or other person to who s and other commission	ist in line 3 (b) To persons). m commiss	the agents, atal amount of	brokers, and o	ther persons in
descending order of the (a) Total a 3 Persons receiving com (b) Amount of sales ar	amount paid. amount of comm missions and fee (a) Name an id base	issions paid es. (Complete as many entries a d address of the agent, broker, c Fees	I commissions paid. L	ist in line 3 (b) To persons). m commiss ns paid (d) Purpose	the agents, interest of the ag	brokers, and o	ther persons in

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	and OMB Control Numbers,	see the instructions for Form 5500.	

Schedule A (Form 5500) 2015 v. 150123

## (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	me and address of the agent, broke	r, 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
(a) Na	me and address of the agent, broke	r, 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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part II		I Investment and Annuity Contract Information	idual contract	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may				
		this report.						
4		rent value of plan's interest under this contract in the general account at year			. 4			
5		rent value of plan's interest under this contract in separate accounts at year e	nd					
6		tracts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier			. 6b			
	С	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			. 6d			
		Specify nature of costs						
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here				
7	Con	ntracts 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	ate participatio	on 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						
		(4) Transferred from separate account						
		(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:	- (1)					
		(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) 7e(4)					
		(4) Other (specify below)						
		•						
		(5) Total deductions			. 7e(5)			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f			

Page 4	
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Pa	rt III	Welfare Benefit Contract Informat	ion				
		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	are experienc	e-rated as a unit. Whe	ere contract	
8	Bene	fit and contract type (check all applicable boxes)					
	a 🗵	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d 🗌 Life insurance
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental unemp	olovment	<b>h</b> Prescription drug
	iX	Stop loss (large deductible)	j HMO contract	_	PPO contract		I Indemnity contract
				ĸ			
	m	Other (specify)					
9	Evno	rience-rated contracts:					
3	•	Premiums: (1) Amount received	]	9a(1)		223938	-
		(2) Increase (decrease) in amount due but unpaid				220000	-
		(3) Increase (decrease) in unearned premium res					-
		(4) Earned ((1) + (2) - (3))				9a(4)	223938
	-	Benefit charges (1) Claims paid					
	(	(2) Increase (decrease) in claim reserves					
	(	(3) Incurred claims (add (1) and (2))	······			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					_
		(G) Other retention charges				0-(4)(1))	
		(H) Total retention		_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These				9c(2)	
		Status of policyholder reserves at end of year: (1	, ,			9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	i în line 90(2).	.)	9e	
10		nexperience-rated contracts:	orrior			10-	
	-	Total premiums or subscription charges paid to c				10a	
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				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?	X Yes	No	
12 If the answer to line 11 is "Yes," specify the information not provided.			

NO COMPANY IDENTIFICATION, POLICY IDENTIFICATION, NAIC CODE, DETAILS FOR SCH A, PART III

SCHEDU (Form 55		Insurance Information				OMB No. 1210-0110	
Department of the T Internal Revenue	Treasury	This schedule is required Employee Retirement In					2015
Department of I Employee Benefits Securit	Labor		attachment to Form 55	•	-y-		2013
Pension Benefit Guarant		<ul> <li>Insurance companies a pursuant to E</li> </ul>	are required to provide ERISA section 103(a)(2		tion	This Fo	rm is Open to Public Inspection
For calendar plan year	2015 or fiscal pla	n year beginning 04/01/2015		and er		/2016	
A Name of plan CHILDERS OIL GROU	JP BENEFITS			B Thre	e-digit number (PN)	•	503
C Plan sponsor's nam CHILDERS OIL CO., I		ne 2a of Form 5500			oyer Identifica 0702219	tion Number	(EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information	on:						
(a) Name of insurance ANTHEM HEALTH PLA							
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a			,	contract year
(2) 2	code	identification number	policy or contract year		(f) F	From	<b>(g)</b> To
61-1237516	95120	000COD834	149		04/04/2015		12/31/2015
descending order of	the amount paid.	ation. Enter the total fees and tot	al commissions paid. L		-		other persons in
(a) 10	tal amount of com	1258		(b)	otal amount of	r tees paid	
<b>3</b> Persons receiving a	commissions and f	lees. (Complete as many entries	as needed to report all	persons).			
	<b>(a)</b> Name a	and address of the agent, broker,		om commiss	ions or fees v	vere paid	
ARCORP LLC		STE 16	VINE STREET 350 GTON, KY 40507				
(b) Amount of sale			es and other commissio	•			_
commissions	paid 62	(c) Amount		(d) Purpose		(e) Organization code	
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees v	vere paid	
COMPREHENSIVE BU	ISINESS INS SOL		OX 1485 N, KY 40702				
(b) Amount of colo	s and base	Fee	es and other commissio	ons paid			
(b) Amount of sales and base commissions paid		(c) Amount	(d) Purpose			(e) Organization code	
	638						3
For Paperwork Reduc	ction Act Notice	and OMB Control Numbers, see	e the instructions for	Form 5500		Sche	edule A (Form 5500) 2015 v. 150123

## (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		(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	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		(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

Part II		I Investment and Annuity Contract Information	idual contract	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may				
		this report.						
4		rent value of plan's interest under this contract in the general account at year			. 4			
5		rent value of plan's interest under this contract in separate accounts at year e	nd					
6		tracts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier			. 6b			
	С	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			. 6d			
		Specify nature of costs						
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here				
7	Con	ntracts 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	ate participatio	on 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						
		(4) Transferred from separate account						
		(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:	- (1)					
		(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) 7e(4)					
		(4) Other (specify below)						
		•						
		(5) Total deductions			. 7e(5)			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f			

Page 4	4
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Pa	art II	Welfare Benefit Contract Informat	ion						
		If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees,							
		the entire group of such individual contracts					is cover individual employee	s,	
8	Bene	fit and contract type (check all applicable boxes)	,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,,						
	a 🗴	7	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance		
	еГ	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	nlovment	<b>h</b> Prescription drug		
					-	ipioyment			
		Stop loss (large deductible)	<b>j</b> HMO contract	ĸ	PPO contract		I Indemnity contract		
	m	Other (specify)							
_	_								
9		rience-rated contracts:		0.(1)	-		4		
		Premiums: (1) Amount received		9a(1)			-		
		(2) Increase (decrease) in amount due but unpaid					-		
		(3) Increase (decrease) in unearned premium res		9a(3)		00(4)			
	-	(4) Earned ((1) + (2) - (3))				9a(4)			
		Benefit charges (1) Claims paid					-		
		(2) Increase (decrease) in claim reserves							
		<ul><li>(4) Claims charged</li><li>Remainder of premium: (1) Retention charges (or</li></ul>							
	C	(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							
		(F) Charges for risks or other contingencies.							
		(G) Other retention charges							
		(H) Total retention				9c(1)(H)			
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)				
	d	Status of policyholder reserves at end of year: (1							
		(2) Claim reserves							
		(3) Other reserves							
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2)</b>	).)				
10	Nor	nexperience-rated contracts:							
		Total premiums or subscription charges paid to c	arrier			10a	44	477	
	-	If the carrier, service, or other organization incur	ed any specific costs in c	onnection wit	th the acquisition or				
		retention of the contract or policy, other than repe	orted in Part I, line 2 abov	e, report amo	ount	10b			

Specify nature of costs 🕨

Part	Provision of Information			
<b>11</b> D	the insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	No
<b>12</b> If	ne answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE C	Service Provide	er Information		OMB No. 1210-0110	
(Form 5500)				0045	
Department of the Treasury Internal Revenue Service	Department of the Treasury This schedule is required to be filed under section 104 of the Employee			2015	
Department of Labor Employee Benefits Security Administration	File as an attachm	File as an attachment to Form 5500.			
Pension Benefit Guaranty Corporation For calendar plan year 2015 or fiscal plan	n year beginning 04/01/2015	and ending 03/3	31/2016	Inspection.	
A Name of plan CHILDERS OIL GROUP BENEFITS		B Three-digit plan number (PN)	•	503	
C Plan sponsor's name as shown on lin CHILDERS OIL CO., INC.	e 2a of Form 5500	D Employer Identifica 61-0702219	tion Numbe	r (EIN)	
You must complete this Part, in accor or more in total compensation (i.e., m plan during the plan year. If a person	rmation (see instructions) dance with the instructions, to report the in oney or anything else of monetary value) received only eligible indirect compensation nclude that person when completing the re-	in connection with services rendered t ion for which the plan received the red	o the plan c	or the person's position with the	
a Check "Yes" or "No" to indicate wheth	ceiving Only Eligible Indirect Co er you are excluding a person from the re lan received the required disclosures (see	mainder of this Part because they rec	•		
2	the name and EIN or address of each per sation. Complete as many entries as nee		s for the ser	vice providers who	

(b) Enter name and EIN or address of person who provided you disclosure 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

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

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

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

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)				
ANTHEM H	HEALTH PLANS OF K	Y, INC.		M. HOWARD TAFT ROAD NATI, OH 45206				
04 400754								
61-123751	61-1237516							
<b>(b)</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 15 49 62		27263	Yes 🗌 No 🔀	Yes 🗌 No 🔀		Yes 🗌 No 🛛		
		(	a) Enter name and EIN or	address (see instructions)				
COMPREF	IENSIVE BUSINESS I	NS. SOLUTIO	P.O. BC CORBIN	)X 1485 N, KY 40702				
			CONDI					
(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?		
16		32180	Yes 🗌 No 🗙	Yes 🗌 No 🔀		Yes 🗌 No 🛛		
	(a) Enter name and EIN or address (see instructions)							
ARCORP L			SUITE1	/INE STREET 650 STON, KY 40507				
61-123751	I	1						
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	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 15 49		23331	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)						
<b>(b)</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 🗌	
		(	a) Enter name and EIN or	address (see instructions)			
<b>(b)</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 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		compensation, 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		
(a) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility
	for or the amount of the	ne indirect compensation.

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Pa	art II	Service Providers Who Fail or Refuse to I	Provide Infori	mation		
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		
	(-) -					
	( <b>a)</b> En	er 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		
	<b>(a)</b> Ent	er 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		
	<b>(a)</b> Ent	er 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		
	<b>(a)</b> Ent	er 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		
	<b>(a)</b> En	er 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>b</b> EIN:		
С	C Position:				
d Address:		SS:	e Telephone:		
Ex	planatio	n:			

Name:	<b>b</b> EIN:
Position:	
Address:	e Telephone:
	Position:

Explanation:

Name:	<b>b</b> EIN:
Position:	
Address:	e Telephone:
	Position:

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation: