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 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

2016

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

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.)
- [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
TED STEVENS, INC. WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/1975

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)

TED STEVENS, INC.

3900 MCHENRY AVE
MODESTO, CA 95353

3900 MCHENRY AVE
MODESTO, CA 95353

2b Employer Identification Number (EIN)
68-0083197

2c Plan Sponsor's telephone number
818-704-8589

2d Business code (see instructions)
441110

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.	07/19/2017	JUDITH ROSEN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/19/2017	JUDITH ROSEN
	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)

ROBYN CASPARY

AMES-GRENZ INSURANCE SERVICES, INC.

3435 AMERICAN RIVER DRIVE, SUITE C
SACRAMENTO, CA 95864

Preparer's telephone number
916-486-2900

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
a	Sponsor's name	**4c**	PN

5	Total number of participants at the beginning of the plan year	**5**	236
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)**	
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	218
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	218
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	218
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 4B 4D 4E 4L

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(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)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 6 **A** (Insurance Information)
- **(4)** [ ] **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 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
TED STEVENS, INC. WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TED STEVENS, INC.

D Employer Identification Number (EIN)
68-0083197

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
PREMIER ACCESS INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
91-1857813	60237	1963	166	01/01/2016	08/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
4292	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4292	0		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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 with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	76475
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
TED STEVENS, INC. WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TED STEVENS, INC.

D Employer Identification Number (EIN)
68-0083197

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
NATIONAL GUARDIAN LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
68-0441908		K73-37211 ET AL	190	09/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
3374	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3374	0		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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 with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	33741
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
TED STEVENS, INC. WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TED STEVENS, INC.

D Employer Identification Number (EIN)
68-0083197

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
NATIONAL GUARDIAN LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
39-0493780	66583	28967	222	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
844	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
844	0		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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 with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [X] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	14710
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
TED STEVENS, INC. WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TED STEVENS, INC.

D Employer Identification Number (EIN)
68-0083197

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678		144142 ET AL	218	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
2150	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2150	0		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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 with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ VOLUNTARY LIFE AND AD&D

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	15849
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
TED STEVENS, INC. WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TED STEVENS, INC.

D Employer Identification Number (EIN)
68-0083197

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
KAISER FOUNDATION HEALTH PLAN. INC.

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
94-1340523	00000	24665	159	09/01/2015	08/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
23531	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
23531	0		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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 with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [X] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	800710
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
TED STEVENS, INC. WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TED STEVENS, INC.

D Employer Identification Number (EIN)
68-0083197

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AMERICAN FIDELITY ASSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
73-0714500	60410	36102 ET AL	88	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
7459	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
AMERICAN FIDELITY ASSURANCE COMPANY
PO BOX 25360
OKLAHOMA CITY, OK 73125

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2810	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4649	0		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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 with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [X] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [X] Indemnity contract
- **m** [X] Other (specify) ▶ ACCIDENT, CANCER AND AD&D

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	90931
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

KAISER PERMANENTE®

Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

STEVENS MANAGEMENT CO
JUDY ROSEN
3900 MCHENRY AVE
MODESTO, CA 95356-1511

Reporting Period: 09/2015 - 08/2016

10/13/2016

Dear STEVENS MANAGEMENT CO:

Enclosed is information from Kaiser Permanente that may assist you in the completion of Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Permanente's Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Permanente during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf, during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums received by Kaiser Permanente during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Permanente processed and deposited your premium payment. The enclosed premium information is not based on coverage or billing periods.

Kaiser Permanente is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist in the completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Permanente value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Permanente
(877) 639-0433

This page is intentionally left blank.

KAISER PERMANENTE®

INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan Inc
Plan Sponsor's Name: STEVENS MANAGEMENT CO

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: CA
Insurance Carrier: Kaiser Foundation Health Plan Inc
Insurance Carrier Employer Identification Number: 94-1340523
Insurance Carrier NAIC Code: 00000
Plan Sponsor Contract or Identification Number: 24665
Approximate number of persons covered at end of policy contract year: 159
Contract Year from 09/2015 - 08/2016

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: $23,531.47
Total Amount of Fees Paid: $0.00

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

Ames-Grenz Insurance Services, Inc.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864-5797

Amount of sales and base commissions paid to Ames-Grenz Insurance Services, Inc.:
$23,531.47
Fees and other compensation paid to Ames-Grenz Insurance Services, Inc.:
$0.00

Bonus Amount: $0.00
Bonus Purpose:
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation:

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00

Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan Inc is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium received by Kaiser Foundation Health Plan Inc during your plan's contract year: $800,710.12

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.

Barbara Ishikawa
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
10/13/2016

PREMIER ACCESS
Dental and Vision

Schedule A
Insurance Information

Policyholder Name: Ted Stevens, Inc.
Policy Number: 1963
Information provided for time period: January 01, 2016 through August 31, 2016

This document provides insurance information applicable to the insurance contracts provided by Premier Access Insurance Company and which is needed to complete the Schedule A (Form 5500) as required by ERISA. ***This document is not a substitute for the actual Schedule A.*** You will need to complete a Schedule A to attach to Form 5500. This data is not intended to be a complete statement of the experience for your group policy.

Part 1 – Information Concerning Insurance Contract Coverage, Fees and Commissions

Name of Insurance Carrier: Premier Access Insurance Company
EIN: 91-1857813
NAIC Code: 60237
Contract or Identification Number: 1963
Approximate number of persons covered at end of policy year or contract year:

Subscriber Dental Insurance	166
Dependent Dental Insurance	111
Total Lives	277

Insurance Fees and Commissions paid to agents, brokers and other persons:

Name and address of the agents, brokers or other persons to whom commissions or fees were paid:	Commission Amount	Fees paid amount	Purpose of fees
Ames-Grenz Insurance Services, Inc. 3435 American River Drive, Suite C Sacramento, California 95864	$4,291.92		
Total	$4,291.92		

Part 3 – Welfare Benefit and Contract Information

Benefit and Contract Type: Dental (Nonexperience-rated contract)

Total Premiums paid to carrier: $76,475.31

Premier Access Insurance Company hereby certifies that this insurance information is complete and accurate.

Prepared by: Premier Access Insurance Company
Date Prepared: Thursday, June 8th , 2017

Cypress ANCILLARY BENEFITS

7510 Shoreline Drive
Stockton, CA 95219
Toll Free (800) 350-3989
Fax (209) 478-5614

Schedule A
Form 5500
Insurance Information
(Use the information below to file your Form 5500)

Date Prepared: March 31, 2017

Plan Sponsor: Ted Stevens, Inc./Marin Acura

The information provided is being reported for the Plan Sponsor's policy period beginning September 1, 2016 and ending December 31, 2016.

Contract or ID No.: K73-37211 & K74-7212 **Approx. No. of Members**: 190

Carrier Information:

Carrier: National Guardian Life Insurance Company
EIN: 68-0441908

Coverage Information:

Contract or ID No. K73-37211 & K74-7212
Approx. No. of Members 190

Insurance Premiums Collected & Commissions Paid:

Premium Paid by Plan Sponsor $33,740.65 Total Commission Paid $3,374.07

Broker Information:

Name: Ames Grenz Insurance Services
Address: 3435 American River, #C
Sacramento, CA 95864
Commission %: 10%

Name:
Address:

Commission %: %

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

► Insurance companies are required to provide this information pursuant to ERISA Section 103(a)(2).

OMB No. 1210-0110

2015

This Form is Open to Public Inspection.

For calendar year 2015 or fiscal plan year beginning and ending

A Name of plan
SUPERIOR VISION PLAN

B Three-digit plan number ►

C Plan sponsor's name as shown on line 2a of Form 5500
TED STEVENS, INC.

D Employer Identification Number (EIN)
94-2392318

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
NATIONAL GUARDIAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
39-0493780	66583	28967	222	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
844	

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

AMES-GRENZ INSURANCE SERVICES, INC
3435 AMERICAN RIVER DR STE C
SACRAMENTO CA 95815

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
844			

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	
6	Contracts With Allocated Funds:		
a	State the basis of premium rates ►		
b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	6d	
	Specify nature of costs ►		
e	Type of contract (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ►		
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ► ☐		
7	Contracts with Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a	Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ►		
b	Balance at the end of the previous year	7b	
c	Additions: (1) Contributions deposited during the year	7c(1)	
	(2) Dividends and credits	7c(2)	
	(3) Interest credited during the year	7c(3)	
	(4) Transferred from separate account	7c(4)	
	(5) Other (specify below) ►	7c(5)	
	(6) Total additions	7c(6)	
d	Total of balance and additions (add lines 7b and 7c(6))	7d	
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	(2) Administration charge made by carrier	7e(2)	
	(3) Transferred to separate account	7e(3)	
	(4) Other (specify below) ►	7e(4)	
	(5) Total deductions	7e(5)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(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 with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a	☐ Health (other than dental or vision)	b	☐ Dental	c	☒ Vision	d	☐ Life insurance
e	☐ Temporary disability (accident and sickness)	f	☐ Long-term disability	g	☐ Supplemental unemployment	h	☐ Prescription drug
i	☐ Stop loss (large deductible)	j	☐ HMO contract	k	☐ PPO contract	l	☐ Indemnity contract
m	☐ Other (specify) ►						

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges: (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) –				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	14710
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs ►			10b	

Part IV Provision of Information

11 Did the 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 ►

Comm. Prem
366.78 3,713.72
1783.28 12,135.04
2,150.06 15,848.76

Unum
1 Fountain Square
Chattanooga, TN 37402

March 11, 2017

STEVENS MANAGEMENT CO.
HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION
3900 MCHENRY AVENUE
MODESDO, CA 95356

PERSONAL & CONFIDENTIAL

Contract/Policy No: 000000144142

Re: Employee Retirement Income Security Act of 1974 (ERISA)
Insurance Information Schedule A (Form 5500)

Unum's policy is to fully disclose and report all compensation associated with the insurance plans we offer in accordance with our internal guidelines and with all applicable regulations. We are pleased to certify the reported Schedule A data with respect to the filing of an ERISA Form 5500 Annual Report.

This information is forwarded to you in the event your company has determined it is required to make this filing. Unum does not take any position or provide any advice on ERISA's applicability to any of your company's benefit plans.

The enclosed Primary Schedule A data is reported by the insuring company and includes all Base Commissions, Supplemental Compensation and Fees paid to a broker/entity for this policy issued by the insuring company during the plan year as reported through Unum's commission systems. If no plan year has been specified in our records the information is for the period reported on the form.

Base Commissions are a fixed percentage of the policy premium, and may include a one time flat amount. If no compensation has been paid, this figure will be zero (.00). If Base Commission is reported, it will be reflected under the Sales Commissions Paid column.

Supplemental Compensation, other than Base Commissions, may be received by a broker/entity for this policy. If no Supplemental Compensation has been paid, this figure will be zero (.00). If Supplemental Compensation is reported, it will be reflected under the Additional Compensation Paid column.

In some instances a broker/entity may receive a Fee for services provided to the policyholder. If no Fee has been paid, this figure will be zero (.00). If a fee is reported, it will be reflected under the Fees Paid column.

The Supplemental Schedule A data identifies any additional or other compensation including, but not limited to, any final payments under prior incentive plans, overrides, and non-cash compensation. If no such additional or other compensation has been paid, this figure will be zero (.00).

If you have any questions regarding the enclosed data or think that you may have received this information in error, contact us at 1-800-ASK-UNUM (1-800-275-8686) or email us at AskUnum@unum.com. We would be glad to assist you with any questions relating to Unum insurance coverages or broker compensation. However, we may not provide legal advice on the applicability of particular laws or regulations to your company. For these issues, you should consult your company's attorneys or other advisors.

We appreciate this opportunity to provide service to you.

Broker Compensation Services

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: STEVENS MANAGEMENT CO.

1. Name of carrier, service or other organization:

   Unum Life Insurance Company of America

   Tax ID: 010278678 NAIC: 62235

2. Contract Number: 000000144142

3. Date for period: from 2016-01-01 to 2017-01-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid
No Additional Compensation		

0000000201489001489 3

03/16/2017

STEVENS MANAGEMENT CO.
HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION
3900 MCHENRY AVENUE
MODESDO CA 95356

00144142
K6\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)
AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: STEVENS MANAGEMENT CO.

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

Unum Life Insurance Company of America

TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 144142

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 218

4. DATE FOR PERIOD: FROM 01-01-2016 TO 01-01-2017

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
Ames-Grenz Insurance Services 3435 American River Dr Ste C Sacramento CA 95864	366.78	.00	.00

6. COVERAGE/BENEFITS PROVIDED: ADD, LIFE

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A)	TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....$	3,713.72
(B)	PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....$	51.00
(C)	IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....$	.00

1000002014690014694

Unum
1 Fountain Square
Chattanooga, TN 37402

April 19, 2017

STEVENS MANAGEMENT CO.
HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION
3900 MCHENRY AVENUE
MODESTO, CA 95356

PERSONAL & CONFIDENTIAL

Contract/Policy No: 000000144143

Re: Employee Retirement Income Security Act of 1974 (ERISA)
Insurance Information Schedule A (Form 5500)

Unum's policy is to fully disclose and report all compensation associated with the insurance plans we offer in accordance with our internal guidelines and with all applicable regulations. We are pleased to certify the reported Schedule A data with respect to the filing of an ERISA Form 5500 Annual Report.

This information is forwarded to you in the event your company has determined it is required to make this filing. Unum does not take any position or provide any advice on ERISA's applicability to any of your company's benefit plans.

The enclosed Primary Schedule A data is reported by the insuring company and includes all Base Commissions, Supplemental Compensation and Fees paid to a broker/entity for this policy issued by the insuring company during the plan year as reported through Unum's commission systems. If no plan year has been specified in our records the information is for the period reported on the form.

Base Commissions are a fixed percentage of the policy premium, and may include a one time flat amount. If no compensation has been paid, this figure will be zero (.00). If Base Commission is reported, it will be reflected under the Sales Commissions Paid column.

Supplemental Compensation, other than Base Commissions, may be received by a broker/entity for this policy. If no Supplemental Compensation has been paid, this figure will be zero (.00). If Supplemental Compensation is reported, it will be reflected under the Additional Compensation Paid column.

In some instances a broker/entity may receive a Fee for services provided to the policyholder. If no Fee has been paid, this figure will be zero (.00). If a fee is reported, it will be reflected under the Fees Paid column.

The Supplemental Schedule A data identifies any additional or other compensation including, but not limited to, any final payments under prior incentive plans, overrides, and non-cash compensation. If no such additional or other compensation has been paid, this figure will be zero (.00).

If you have any questions regarding the enclosed data or think that you may have received this information in error, contact us at 1-800-ASK-UNUM (1-800-275-8686) or email us at AskUnum@unum.com. We would be glad to assist you with any questions relating to Unum insurance coverages or broker compensation. However, we may not provide legal advice on the applicability of particular laws or regulations to your company. For these issues, you should consult your company's attorneys or other advisors.

We appreciate this opportunity to provide service to you.

Broker Compensation Services

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: STEVENS MANAGEMENT CO.

1. Name of carrier, service or other organization:

   Unum Life Insurance Company of America

   Tax ID: 010278678 NAIC: 62235

2. Contract Number: 000000144143
3. Date for period: from 2016-01-01 to 2017-01-01

4. Additional Broker Compensation:

Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid

No Additional Compensation

04/24/2017
STEVENS MANAGEMENT CO.
HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION
3900 MCHENRY AVENUE
MODESTO CA 95356

00144143
K6\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: STEVENS MANAGEMENT CO.

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

Unum Life Insurance Company of America

TAX ID: 010278678 NAIC: 62235

2. CONTRACT NUMBER: 144143

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 026

4. DATE FOR PERIOD: FROM 01-01-2016 TO 01-01-2017

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
Ames-Grenz Insurance Services 3435 American River Dr Ste C Sacramento CA 95864	1,783.28	.00	.00

6. COVERAGE/BENEFITS PROVIDED: LIFESTYLE ADD, LIFESTYLE LIFE

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A)	TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER	$ 12,135.04
(B)	PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR	$ 304.78
(C)	IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT	$ .00

Schedule A Report

FRESNO ACURA ATTN GILLIE COSTALES
7250 N PALM AVE FRESNO, CA 93711

Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

FRESNO ACURA (36102)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
Accident Only	**21**	**$2,685.64**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$478.44	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$138.28	0.00
			Total Accident Only:	**$616.72**	**0.00**
Cancer	**5**	**$1,482.84**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$75.56	0.00
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$8.01	0.00
			Total Cancer:	**$83.57**	**0.00**
LTD	**13**	**$8,868.44**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$443.55	0.00

Schedule A Report

FRESNO ACURA ATTN GILLIE COSTALES
7250 N PALM AVE FRESNO, CA 93711
Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

FRESNO ACURA (36102)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$10.67	0.00
			Total LTD:	**$454.22**	**0.00**
Medical Group	**6**	**$55.44**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$66.40	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$2.76	0.00
			Total Medical Group:	**$69.16**	**0.00**
STD	**0**	**$430.40**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$43.12	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$21.56	0.00
			Total STD:	**$64.68**	**0.00**

Schedule A Report

GILROY HONDA ATTN BONNI MARTIN GALAZ
17100 LAUREL RD MORGAN HILL, CA 95037

Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

HONDA OF MORGAN HILL (36103)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
Accident Only	**7**	**$2,984.76**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$159.98	0.00
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	($209.72)	0.00
			Total Accident Only:	**($49.74)**	**0.00**
AD&D	**0**	**$72.00**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$3.60	0.00
			Total AD&D:	**$3.60**	**0.00**
Cancer	**10**	**$2,698.44**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$135.68	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$134.98	0.00
			Total Cancer:	**$270.66**	**0.00**
LTD	**19**	**$17,349.14**			

Schedule A Report

GILROY HONDA ATTN BONNI MARTIN GALAZ
17100 LAUREL RD MORGAN HILL, CA 95037

Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

HONDA OF MORGAN HILL (36103)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$867.62	0.00
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$191.50	0.00
			Total LTD:	**$1,059.12**	**0.00**
Medical Group	**12**	**$263.20**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$165.47	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$13.16	0.00
			Total Medical Group:	**$178.63**	**0.00**
STD	**3**	**$3,228.62**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$161.61	0.00
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	($25.46)	0.00
			Total STD:	**$136.15**	**0.00**

Schedule A Report

MARIN ACURA ATTN ROBERTA KENNEY
PO BOX 218 CORTE MADERA, CA 94976

Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

MARIN ACURA (55948)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
Accident Only	**12**	**$3,639.34**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$218.84	0.00
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	($251.27)	0.00
			Total Accident Only:	**($32.43)**	**0.00**
AD&D	**0**	**$24.00**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$15.97	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$1.20	0.00
			Total AD&D:	**$17.17**	**0.00**
LTD	**9**	**$14,190.82**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$722.41	0.00

Schedule A Report

MARIN ACURA ATTN ROBERTA KENNEY
PO BOX 218 CORTE MADERA, CA 94976

Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

MARIN ACURA (55948)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	($175.13)	0.00
			Total LTD:	**$547.28**	**0.00**
Medical Group	**3**	**$143.92**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$86.17	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$7.20	0.00
			Total Medical Group:	**$93.37**	**0.00**
STD	**1**	**$1,687.20**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$95.82	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$84.42	0.00
			Total STD:	**$180.24**	**0.00**

Schedule A Report

Modesto Subaru ATTN BONNI GALAZ
4360 MCHENRY AVE MODESTO, CA 95356
Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

MODESTO SUBARU (97176)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
Accident Only	**9**	**$1,037.58**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$305.90	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$54.72	0.00
			Total Accident Only:	**$360.62**	**0.00**
Cancer	**1**	**$317.68**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$15.84	0.00
			Total Cancer:	**$15.84**	**0.00**
LTD	**15**	**$9,710.68**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$485.67	0.00
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$425.65	0.00
			Total LTD:	**$911.32**	**0.00**
Medical Group	**12**	**$325.38**			

Schedule A Report

Modesto Subaru ATTN BONNI GALAZ
4360 MCHENRY AVE MODESTO, CA 95356
Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

MODESTO SUBARU (97176)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$259.76	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$16.29	0.00
			Total Medical Group:	**$276.05**	**0.00**
STD	**0**	**$488.32**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$129.35	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$24.46	0.00
			Total STD:	**$153.81**	**0.00**

Schedule A Report

MODESTO EUROPEAN ATTN BONNI GALAZ
3900 MCHENRY AVE MODESTO, CA 95356

Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

MERCEDES BENZ OF MODESTO (39616)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
Accident Only	**12**	**$3,282.18**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$173.34	0.00
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$165.27	0.00
			Total Accident Only:	**$338.61**	**0.00**
Cancer	**8**	**$1,816.14**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$123.32	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$97.78	0.00
			Total Cancer:	**$221.10**	**0.00**
LTD	**15**	**$12,595.42**			
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$646.77	0.00

Schedule A Report

MODESTO EUROPEAN ATTN BONNI GALAZ
3900 MCHENRY AVE MODESTO, CA 95356

Plan/Contract Year: 1/1/2016 - 12/31/2016
Part I (a) Name of Insurance Carrier: American Fidelity Assurance Company
Part I (b) EIN: 73-0714500
Part I (c) NAIC Code: 60410

MERCEDES BENZ OF MODESTO (39616)

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at End of Contract Year	Part III, Sec 9a Total Premium or Subscription Charges to Carrier	Part I, Sec 2 Name and Address of the Agents	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 Total Fees Paid
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	($186.90)	0.00
			Total LTD:	**$459.87**	**0.00**
Medical Group	**21**	**$919.98**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$734.45	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$46.02	0.00
			Total Medical Group:	**$780.47**	**0.00**
STD	**1**	**$633.48**			
			AMERICAN FIDELITY ASSURANCE COMPANY P. O. BOX 25360 OKLAHOMA CITY, OK 73125-0360	$218.24	0.00
			AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR #C SACRAMENTO, CA 95864	$31.68	0.00
			Total STD:	**$249.92**	**0.00**