#### 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

						inspection	
Part I		lentification Information					
For caler	ndar plan year 2016 or fisc	cal 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 participating employer information in accordance)							ons.)
		x a single-employer plan	a DFE (specif	fy)			
<b>B</b> This r	return/report is:	the first return/report	the final return	n/report			
	·	an amended return/report	a short plan y	ear return/report (less than 12 m	nonths)	onths)	
C If the	plan is a collectively-barga	ained plan, check here				• []	
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exte	ension	the	e DFVC program	
		special extension (enter descripti	on)				
Part II	Basic Plan Inforr	nation—enter all requested informa	ation				
	ne of plan	·			1b	Three-digit plan	504
DIALOG	DIRECT WELFARE BEN	NEFITS PLAN			<u> </u>	number (PN) ▶	501
					1c	Effective date of p 01/01/2013	lan
		er, if for a single-employer plan)	)		2b	Employer Identifica	ation
		, apt., suite no. and street, or P.O. Bo , country, and ZIP or foreign postal co		ructions)		Number (EIN) 46-1570786	
•	DIRECT, INC.	3 1	· • • ·	,	2c	Plan Sponsor's tel	ephone
						number	•
						248-598-0163	
	AKLAND AVENUE		DAKLAND AVENUE		2d	2d Business code (see	
HIGHLAN	ND PARK, FL 48203	HIGHLA	ND PARK, FL 48203		instructions) 561490		
Caution	: A penalty for the late or	r incomplete filing of this return/rep	port will be assessed	unless reasonable cause is e	stablis	shed.	
Under pe	enalties of perjury and other	er penalties set forth in the instruction	s, I declare that I have	e examined this return/report, inc	luding	accompanying sche	edules,
statemer	nts and attachments, as we	ell as the electronic version of this ret	urn/report, and to the l	best of my knowledge and belief	, it is tr	rue, correct, and cor	nplete.
SIGN HERE	Filed with authorized/valid	d electronic signature.	07/21/2017	KERRI CLARK			
HERE	Signature of plan admi	nistrator	Date	Enter name of individual sign	ing as	plan administrator	
SIGN							
HERE	Signature of employer/	plan sponsor	Date	Enter name of individual sign	ing as	employer or plan sp	onsor
SIGN							
HERE	Signature of DFE		Date	Enter name of individual sign	ing as	DFE	
Preparer		me, if applicable) and address (includ				telephone number	

Form 5500 (2016) Page **2** 

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	3a	Plan administrator's name and address X Same as Plan Sponsor	<b>3b</b> Adm	<b>3b</b> Administrator's EIN		
ERIA and the plan number from the last return/report:  a Sponsor's name  5 Total number of participants at the beginning of the plan year  6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(1) 244  a(2) Total number of active participants at the beginning of the plan year.  6 a(1) 24  a(2) Total number of active participants at the end of the plan year.  6 a(2) 233  b Retired or separated participants receiving benefits.  6 b  C Other retired or separated participants entitled to future benefits.  6 b  6 c  6 c  6 d  6 c  6 d  6 c  7 ottal. Add lines 6a(2), 6b, and 6c.  6 d  6 d  6 d  7 ottal. Add lines 6d and 6e.  6 d  7 ottal. Add lines 6d and 6e.  6 d  7 ottal. Add lines 6d and 6e.  6 d  8 outputs and 6 d  8 outputs and 6 d  8 outputs and 6 d  9 outputs and 6 d  9 outputs and 6 d  10 outputs and 6 d  9 outputs and 6 d  10 outputs and 6 d						
Total number of participants at the beginning of the plan year will account to the plan year will account balances 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	4		n/report filed for this plan, enter the name,	4b EIN		
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	а	·		4c PN		
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(2) 233  b Retired or separated participants receiving benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants with account participants with account belances are receiving or are entitled to receive benefits.  6 C Other retired or separated participants whose beneficiaries are receiving or are entitled to receive benefits.  6 C Other retired or separated participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  6 G Other participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  6 G Other participants with account balances as of the end of the plan year with accrued benefits that were less than 100% vested .  7 Enter the total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .  8 If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  4 A 4 B 4 D 4 E 4 F 4 H 4 L  9 Plan lunding arrangement (check all that apply)  (1) 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 a	5	Total number of participants at the beginning of the plan year		5	2452	
A (2) Total number of active participants at the end of the plan year	6		d (welfare plans complete only lines 6a(1),			
b Retired or separated participants receiving benefits.  c Other retired or separated participants entitled to future benefits.  d Subtotal. Add lines 6a(2), 6b, and 6c	a(1	) Total number of active participants at the beginning of the plan year		6a(1)	2452	
C Other retired or separated participants entitled to future benefits	a(2	Total number of active participants at the end of the plan year		6a(2)	2357	
d Subtotal. Add lines 6a(2), 6b, and 6c	b	Retired or separated participants receiving benefits		6b		
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.  f Total. Add lines 6d and 6e.  g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  h Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.  f Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	С	Other retired or separated participants entitled to future benefits		6c	22	
f Total. Add lines 6d and 6e	d	Subtotal. Add lines 6a(2), 6b, and 6c		6d	2379	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits	6e		
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.  7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	f	Total. Add lines 6d and 6e		6f	2379	
less than 100% vested	g			6g		
Ba If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:    b   If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:   4A   4B   4D   4E   4F   4H   4L     9a   Plan funding arrangement (check all that apply)   (1)	h			6h		
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4A 4B 4D 4E 4F 4H 4L  9a Plan funding arrangement (check all that apply)  (1)	7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plans complete this item)	7		
(1)	b	If the plan provides welfare benefits, enter the applicable welfare feature coc 4A 4B 4D 4E 4F 4H 4L	les from the List of Plan Characteristics Codes	s in the ins		
Code section 412(e)(3) insurance contracts  (3) Trust (4) General assets of the sponsor  (4) X 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) Trust  (4) X General assets of the sponsor  b General Schedules  (1) H (Financial Information)  (1) H (Financial Information)  (2) I (Financial Information – Small Plan)  (3) X 9 A (Insurance Information)  C (Service Provider Information)  (3) D (DFE/Participating Plan Information)	9a			at apply)		
(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  (4) Seneral assets of the sponsor  (4) Financial Information - Small Plan  (5) C (Service Provider Information)  (6) D (DFE/Participating Plan Information)		``		insurance	contracts	
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  (5) D (DFE/Participating Plan Information)			I <del>-</del>			
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 (5) General Schedules (1) H (Financial Information) (2) I (Financial Information – Small Plan) (3) 9 A (Insurance Information) (4) C (Service Provider Information) D (DFE/Participating Plan Information)	10				ad (See instructions)	
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) Q				de attache	ed. (See mandenons)	
(1) H (Financial 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  (4) D (DFE/Participating Plan Information)	а					
Purchase Plan Actuarial Information) - signed by the plan actuary  (3)				,		
(+)		Purchase Plan Actuarial Information) - signed by the plan	(3) 9 A (Insurance Infor	mation)	,	
				-		

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.)					
lf "Y€	es" is checked, complete lines 11b and 11c.				
<b>11b</b> Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
Rece	r 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 eipt 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 eipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
Rece	eipt Confirmation Code				

Form 5500 (2016)

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).				Inspection			
For calendar plan year 20	016 or fiscal plan	year beginning 01/01/2016		and en	nding 12/3	1/2016	-
A Name of plan DIALOG DIRECT WELFARE BENEFITS PLAN					e-digit number (Pl	N) <b>•</b>	501
C Plan sponsor's name as shown on line 2a of Form 5500 DIALOG DIRECT, INC.  D Employer Identification Num 46-1570786					ation Number (	EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance of DELTA DENTAL OF MICH							
/L) FIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
38-1791480	54305	0001740	1432		01/01/2016	6	12/31/2016
2 Insurance fee and con descending order of th		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total	amount of comr			<b>(b)</b> To	otal amount	of fees paid	
25130 0							
3 Persons receiving con	nmissions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		n commiss	ions or fees	were paid	
MERCER HEALTH AND E	BENEFITS, LLC		AYSPHERE CIR GO, IL 60674				
(b) Amount of sales a	and base	Fee	s and other commissior	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
25130						3	
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales a	and base	Fee	s and other commissior	sions paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code
For Donomyouk Dodynati	on Act Notice	coo the Instructions for Form F	500			Cohoo	tulo A (Form FF00) 2046

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code	
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
	_			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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Pa	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 1	reated as a unit for p	urposes of t	nis report.	
8	Benef	efit and contract type (check all applicable boxes)			•		. —	
	a	Health (other than dental or vision) <b>b</b> 🗓 Dental	(	C	Vision		<b>d</b> Life	insurance
	e 🗌	Temporary disability (accident and sickness) <b>f</b> Long-term	disability	g 🗌	Supplemental unem	ployment	<b>h</b> Pre	scription drug
	i 🔲	Stop loss (large deductible) j HMO contri	act I	kΠ	PPO contract		I Inde	emnity contract
	m∏	Other (specify)						
	Ш	(-p), ·						
9 1	Exper	rience-rated contracts:						
	<b>a</b> Pi	Premiums: (1) Amount received	9a(1)		-	501619	)	
		(2) Increase (decrease) in amount due but unpaid	- (-)		-	40233		
	(;	(3) Increase (decrease) in unearned premium reserve	9a(3)					
	(-	(4) Earned ((1) + (2) - (3))				9a(4)		541852
	b	Benefit charges (1) Claims paid	9b(1)			473486	3	
	(2	(2) Increase (decrease) in claim reserves	9b(2)			-902	2	
	(;	(3) Incurred claims (add (1) and (2))				9b(3)		472584
	(4	(4) Claims charged	•••••			9b(4)		
	C F	Remainder of premium: (1) Retention charges (on an accrual basis	s)					
		(A) Commissions	9c(1)(A	(۱		25131		
		(B) Administrative service or other fees				29345	5	
		(C) Other specific acquisition costs		-				
		(D) Other expenses						
		(E) Taxes		_		8128	3	
		(F) Charges for risks or other contingencies				9626	5	
		(G) Other retention charges				0 (4)(1)		
		(H) Total retention				9c(1)(H)	)	72230
		(2) Dividends or retroactive rate refunds. (These amounts were				9c(2)		
		Status of policyholder reserves at end of year: (1) Amount held to ${\bf p}$				9d(1)		
		(2) Claim reserves				9d(2)		12730
	,	(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do not include amount	entered in line 90	(2).	<u>)</u>	9e		
10		nexperience-rated contracts:						
	_	Total premiums or subscription charges paid to carrier				10a		
		If the carrier, service, or other organization incurred any specific co				10h		
		retention of the contract or policy, other than reported in Part I, line cify nature of costs.	2 above, report a	amo	unt	10b		
	Opeci	ony nature of costs.						
D	art IV	V Provision of Information						
		the insurance company fail to provide any information necessary to	-	dule	A?	Yes	× No	
12	If the	ne answer to line 11 is "Yes," specify the information not provided.	<b>&gt;</b>					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					111101011	Inspection	
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016		and en	nding 12/3	1/2016	
A Name of plan DIALOG DIRECT WELFA	RE BENEFITS	PLAN			e-digit number (PI	N) •	501
C Plan sponsor's name a DIALOG DIRECT, INC.	as shown on line	e 2a of Form 5500		-	oyer Identific 1570786	ation Number (	EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca DELTA DENTAL OF MICH							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
38-1797480	54305	0008214	268		01/01/2016	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Total	amount of comr			<b>(b)</b> To	otal amount	of fees paid	
		3070					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LLC		AYSPHERE CIR GO, IL 60674				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount	(c		(d) Purpose		(e) Organization code
	3070						3
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
	(2)						
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	A ( N) (1						(= =====)

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code	
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
	_			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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ay		•

F	art	II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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Pa	art III	Welfare Benefit Contract Information may be combined for report employees, the entire group of such individ	group of employees of the ng purposes if such cont	racts are e	xperience-rated as a	unit. Where co	ontracts cover individual
8	Benefit	and contract type (check all applicable boxes)					
	a ∏ ⊦	lealth (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> Life insurance
	е 🗖 т	emporary disability (accident and sickness)	f Long-term disabili	tv <b>a</b>	Supplemental un	employment	h Prescription drug
	=	Stop loss (large deductible)	j HMO contract		PPO contract		I  Indemnity contract
		Other (specify)					I I macrimity contract
	⊔ ⟨	other (specify)					
9 F	xperier	nce-rated contracts:					
		miums: (1) Amount received		9a(1)		59756	
		Increase (decrease) in amount due but unpaid		9a(2)		3848	Ti .
		Increase (decrease) in unearned premium res		9a(3)		3040	
		Earned ((1) + (2) - (3))				9a(4)	63604
	_	nefit charges (1) Claims paid		9b(1)		42582	
		Increase (decrease) in claim reserves		9b(2)		-720	
		Incurred claims (add (1) and (2))				1	41862
							41002
	. ,	Claims charged				95(4)	
	<b>C</b> Re	mainder of premium: (1) Retention charges (o	,	0-(4)(A)	<u>. T</u>	000005	
		(A) Commissions		9c(1)(A)		306985	i
		(B) Administrative service or other fees		9c(1)(B)		2864	<u> </u>
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)		954	
		(F) Charges for risks or other contingencies .		9c(1)(F)		1590	
		(G) Other retention charges		9c(1)(G	)		
		(H) Total retention				9c(1)(H)	312393
	(2)	Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)	9c(2)	
	<b>d</b> Sta	atus of policyholder reserves at end of year: (1	Amount held to provide	benefits af	⊐ ter retirement		
		Claim reserves	•				1347
	` '	Other reserves					
	` '	vidends or retroactive rate refunds due. (Do no					
10		perience-rated contracts:	t inolado amodni cintoro	4 III III IC <b>30</b>	<b>(=)</b> -,		
			arriar			10a	
		tal premiums or subscription charges paid to c					
		he carrier, service, or other organization incurr					
		ention of the contract or policy, other than repo nature of costs.	orted in Part I, line 2 abov	e, report a	mount	10b	
D-	r4 I\/	Provision of Information					
	rt IV	Provision of Information					
11		e insurance company fail to provide any inform		ete Sched	ule A?	Yes	X No
12	12 If the answer to line 11 is "Yes," specify the information not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to El	RISA section 103(a)(2).		IIIIS FOI	Inspection
For calendar plan year 20	16 or fiscal plar	n year beginning 01/01/2016	and	ending 12/3	31/2016	•
A Name of plan DIALOG DIRECT WELFA	ARE BENEFITS	PLAN		nree-digit an number (P	N) <b>•</b>	501
C Plan sponsor's name a DIALOG DIRECT, INC.	as shown on lin	e 2a of Form 5500		ployer Identific 6-1570786	cation Number	(EIN)
		ning Insurance Contract . Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca		H AMERICA				
(1) FIN	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	<b>(g)</b> To
23-1503749	65498	OK 961598	2357	01/01/201	6	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	commissions paid. List in line	3 the agents,	, brokers, and o	ther persons in
(a) Total	amount of comi		(b)	Total amount	of fees paid	
		2600				
3 Persons receiving com	nmissions and fe	ees. (Complete as many entries a	as needed to report all persons	).		
	(a) Name a	and address of the agent, broker, o		issions or fees	s were paid	
MERCER HEALTH & BEN	EFITS		YSPHERE CIR O, IL 60674			
(b) Amount of sales a	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	<b>(d)</b> Purp	(e) Organization code		
	2422	178 SU	PPLEMENTAL COMMISSION			3
	(a) Name a	and address of the agent, broker, o	or other person to whom comm	issions or fees	s were paid	
			·			
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	<b>(d)</b> Purp	ose		(e) Organization code
- <u>-</u>		see the Instructions for Form 55				dulo A (Form FF00) 2016

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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F	art	II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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Pa	art I	III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of th ting purposes if such con	tracts are expe	erience-rated as a uni	t. Where co	ontract	s cover individual
8	Bene	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		d	Life insurance
	еĪ	Te	emporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unem	ployment	hΠ	Prescription drug
	ιĖ	_	op loss (large deductible)	j  HMO contract		PPO contract	, ,	- =	Indemnity contract
	m [		ther (specify) ACCIDENTAL DEATH			] 11 0 001111401		- □	maoning somas
9 1	Ехре	erien	ce-rated contracts:						
			iums: (1) Amount received		9a(1)				
		(2) l	ncrease (decrease) in amount due but unpai	d	9a(2)				
		(3) l	ncrease (decrease) in unearned premium res	serve	9a(3)		1		
		(4) E	Earned ((1) + (2) - (3))				. 9a(4)		
			efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				1		
		(3) I	ncurred claims (add (1) and (2))				9b(3)		
		` '	Claims charged				9b(4)		
	С	Ren	nainder 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		0 - (4)(0)			_	
			(G) Other retention charges				00(4)(H)		
			(H) Total retention	_			9c(1)(H)	<b>'</b>	
			Dividends or retroactive rate refunds. (These				9c(2)		
	d		rus of policyholder reserves at end of year: (1				9d(1)		
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				9d(3)		
10			dends or retroactive rate refunds due. (Do n	ot include amount entere	a in line 9c(2)	.)	9e		
10			erience-rated contracts:				100		0.404.0
	_		al premiums or subscription charges paid to				10a		24218
	b		e carrier, service, or other organization incur ntion of the contract or policy, other than rep				10b		
	Spe		nature of costs.	onted in Part I, line 2 abov	ve, report arric	Juni	100		
Pa	art I	V	Provision of Information						
			insurance company fail to provide any inform	nation necessary to comm	olete Schedule	А?П	Yes	X No	 )
			nswer to line 11 is "Yes," specify the informat		3.2 2004410		-		
. 4	11 U	ııc al	iorroi to inio i i io i ioo, openiny the inioinidi	ion not provided. 🔻					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2016

This Form is Open to Public

		pursuant to I	ERISA section 103(a)(2)			1	Inspection
For calendar plan year 20	16 or fiscal plar	n year beginning 01/01/2016		and er	nding 12/31	1/2016	
A Name of plan DIALOG DIRECT WELFA	RE RENEEITS	ΡΙ ΔΝ		<b>B</b> Thre	•	501	
DIALOG DIRLOT WELLA	INE DENETITO	TEAN		plan	number (PN	1)	301
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		-	-	ation Number	(EIN)
DIALOG DIRECT, INC.				46-	1570786		
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees.	and Con	nmissions	S Provide info	rmation for each contract
		. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrior						
LIFE INSURANCE COMPA		ICA					
	1	1			1		
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year
	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
23-1503749	65498	FLX961507	2873		01/01/2016	5	12/31/2016
2 Insurance fee and com	mission informa	ation. Enter the total fees and to	al commissions paid I	ist in line 3	the agents	brokers and o	ther persons in
descending order of the		ation. Enter the total roco and to	ai commissions paid. E		tilo agonto, i	brokers, and c	and persons in
(a) Total a	amount of comr			<b>(b)</b> To	otal amount o	of fees paid	
		15256					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BENI	EFITS		AYSPHERE CIR GO, IL 60674				
		OFIIOA	OO, 12 0007 4				
(b) Amount of sales ar	nd hase	Fee	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	14217	1039 SI	UPPLEMENTAL COMM	ISSION			3
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			_
commissions pai		(c) Amount	(d) Purpose				(e) Organization code
For Paperwork Reductio	n Act Notice,	see the Instructions for Form	5500.			Sche	dule A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4						
_		ent value of plan's interest under this contract in separate accounts at year e		4 5		
_		racts With Allocated Funds:			<u> </u>	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa,			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

Pa	art I	III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of th ting purposes if such con	tracts are expe	erience-rated as a uni	t. Where co	ontracts	cover individual
8	Bene	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		d X L	ife insurance
	еĪ	_ Te	emporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unem	ployment	h∏F	rescription drug
	ιĖ	_	op loss (large deductible)	j  HMO contract	· <u> </u>	PPO contract	, ,	- 1	ndemnity contract
	m [	_	ther (specify)		·· _	117 0 0011111101		•□	identific contract
9 [	Ехре	erien	ce-rated contracts:						
	a F	Prem	iums: (1) Amount received		9a(1)				
		(2) lı	ncrease (decrease) in amount due but unpai	d	9a(2)				
		(3) lı	ncrease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	Earned ((1) + (2) - (3))				. 9a(4)		
			efit charges (1) Claims paid					_	
			ncrease (decrease) in claim reserves				1		
		(3) lı	ncurred claims (add (1) and (2))				9b(3)		
		` '	Claims charged				9b(4)		
	С	Ren	nainder 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)			4	
			(D) Other expenses		9c(1)(D)			_	
			(E) Taxes		9c(1)(E)			_	
			(F) Charges for risks or other contingencies		0 - (4)(0)			-	
			(G) Other retention charges				9c(1)(H)		
			(H) Total retention	_	_			<del>'</del>	
			Dividends or retroactive rate refunds. (These				9c(2)		
	d		rus of policyholder reserves at end of year: (1				9d(1)		
		` '	Claim reserves				9d(2)		
	^	` '	Other reserves				9d(3)		
10			dends or retroactive rate refunds due. (Do nerience-rated contracts:	ot include amount entere	a in line 90(2).	.)	9e		
10			al premiums or subscription charges paid to	carrior			10a		144609
							10a		144008
	b		e carrier, service, or other organization incur ntion of the contract or policy, other than rep				10b		
	Spe		nature of costs.	ofted in Fait I, life 2 abo	ve, report arrio	,uiit	100		
Pa	art I	٧	Provision of Information						
			insurance company fail to provide any inform	nation necessary to comp	lete Schedule	А?	Yes	X No	
			nswer to line 11 is "Yes," specify the informat			<u> </u>			
			is mic in its intermediate	p. o dou. ,					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

			RISA section 103(a)(2).	Jiiialion	Inis For	m is Open to Public Inspection		
For calendar plan year 20	16 or fiscal plar	n year beginning 01/01/2016	a	nd ending 12/3	1/2016			
A Name of plan DIALOG DIRECT WELFA	RE BENEFITS	PLAN	В	Three-digit plan number (Pl	N) <b>•</b>	501		
C Plan sponsor's name a DIALOG DIRECT, INC.	s shown on lin	e 2a of Form 5500	D E	Employer Identific 46-1570786	ation Number	(EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca		ICA						
(I.) FIN	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or c	r contract year		
(b) EIN	code	identification number	persons covered at end policy or contract year	Of (f)	From	<b>(g)</b> To		
23-1503749	65498	LK 750330	789	01/01/2016	6	12/31/2016		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List in l	ine 3 the agents,	brokers, and o	ther persons in		
(a) Total	amount of com	missions paid		<b>(b)</b> Total amount	of fees paid			
		19477						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all perso	ns).				
	. ,	and address of the agent, broker,	or other person to whom com	missions or fees	were paid			
MERCER HEALTH & BEN	EFITS		AYSPHERE CIR GO, IL 60674					
(b) Amount of sales ar	nd base	Fee	s and other commissions pai	d				
commissions pa	ĺ	(c) Amount	(d) Purpose			(e) Organization code		
18171 1305 SUPPLEMENTAL COMMISSION 3					3			
	(a) Name a	and address of the agent, broker,	or other person to whom com	missions or fees	were paid			
			·		·			
(b) Amount of sales ar	nd base	Fee	s and other commissions paid	ons paid				
commissions pa		(c) Amount	<b>(d)</b> Pu	(d) Purpose		(e) Organization code		
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	500.		Sche	dule A (Form 5500) 2016		

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4						
_		ent value of plan's interest under this contract in separate accounts at year e		4 5		
_		racts With Allocated Funds:			<u> </u>	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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Pa	ırt l	III Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	g purposes if such conti	racts are expe	erience-rated as a unit	. Where co	ontracts cover individual
<b>8</b> E	3en	nefit and contract type (check all applicable boxes)					
;	аΓ	Health (other than dental or vision)	Dental	с	Vision		<b>d</b> Life insurance
	e [	Temporary disability (accident and sickness)	Long-term disabilit		Supplemental unemp	olovment	h Prescription drug
	· [	Stop loss (large deductible)	HMO contract	- <u>-</u>	PPO contract	oloyillolli.	I  Indemnity contract
	' [ [		I TIMO CONTIACT	κ	FFO Contract		I I indemnity contract
	m	Other (specify)					
9 E		oriones rated contracts:					
_	•	Promiumo: (1) Amount received		00/1)			
•		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2) 9a(3)			
		(3) Increase (decrease) in unearned premium reserved. (4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		. 3a(4)	
		(2) Increase (decrease) in claim reserves		9b(1) 9b(2)			_
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(3)	
	С	Remainder of premium: (1) Retention charges (on				35(4)	
	Ū	(A) Commissions	· ·	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies					
		(G) Other retention charges					
		(H) Total retention				9c(1)(H)	)
		(2) Dividends or retroactive rate refunds. (These a	mounts were ☐ paid in	cash. or $\Box$	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)				9d(1)	
	~	(2) Claim reserves	·			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not				9e	
10		onexperience-rated contracts:			,		
		Total premiums or subscription charges paid to car	rier			10a	18171
	b	If the carrier, service, or other organization incurred	d any specific costs in c	onnection with	h the acquisition or		
	-	retention of the contract or policy, other than report				10b	
;	Spe	ecify nature of costs.					
Pa	rt I	IV Provision of Information					
		d the insurance company fail to provide any information	ion necessary to compl	ete Schedule	А?	Yes	X No
		the answer to line 11 is "Yes." specify the information					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

			RISA section 103(a)(2).	I his Fol	rm is Open to Public Inspection
For calendar plan year	2016 or fiscal plar	n year beginning 01/01/2016	and en	iding 12/31/2016	
A Name of plan DIALOG DIRECT WEL	FARE BENEFITS	PLAN		e-digit number (PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500  DIALOG DIRECT, INC.  D Employer Identification No. 46-1570786					(EIN)
		rning Insurance Contract Lindividual contracts grouped as			
1 Coverage Information	n:				
(a) Name of insurance LIFE INSURANCE COM		ICA			
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	(f) From	(g) To
23-1503749	65498	LK 961194	724	01/01/2016	12/31/2016
2 Insurance fee and co descending order of t		ation. Enter the total fees and tota	I commissions paid. List in line 3	the agents, brokers, and o	other persons in
<b>(a)</b> Tota	al amount of com		<b>(b)</b> To	otal amount of fees paid	
		7847			
3 Persons receiving co	ommissions and fe	ees. (Complete as many entries a	as needed to report all persons).		
	<u>, , ,</u>	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
MERCER HEALTH & BE	ENEFITS		YSPHERE CIR O, IL 60674		
(b) Amount of sales	and base	Fees	and other commissions paid		
commissions		(c) Amount	(d) Purpos	(e) Organization code	
7322 525 SUPPLEMENTAL COMMISSION 3					3
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
(b) Amount of sales	and base		and other commissions paid		
commissions		(c) Amount	(d) Purpos	e	(e) Organization code
For Panerwork Reduc	tion Act Notice	see the Instructions for Form 55	500.	Sche	dule A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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P	art II							
		If more than one contract covers the same group of ending the information may be combined for reporting purpose employees, the entire group of such individual contract.	es if such contr	acts are expe	rience-rated as a uni	. Where con	tract	s cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) <b>b</b> De	ntal	с	Vision	(		Life insurance
	еĒ		g-term disability	v <b>a</b> ∐	Supplemental unem	olovment <b>i</b>	า⊟ี	Prescription drug
	ιĖ		O contract		PPO contract	,	브	Indemnity contract
	m	Other (specify)		🗀			ш	,
9	Expe	erience-rated contracts:						
	•	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)		
		Benefit charges (1) Claims paid	Г	9b(1)				
		(2) Increase (decrease) in claim reserves	F	9b(2)				
	(	(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accru	al 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	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount I	neld to provide b	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include	amount entered	in line 9c(2).	)	9e		
10	Nor	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		73219
	b	If the carrier, service, or other organization incurred any spe	ecific costs in co	onnection with	the acquisition or			
		retention of the contract or policy, other than reported in Pa	rt I, line 2 above	e, report amo	unt	10b		
	Spec	ecify nature of costs.						
_	,	N. Brasisian (Inf. 2)						
	art I\				<del></del>	-		_
11	Did	d the insurance company fail to provide any information nece	ssary to comple	ete Schedule	A?	Yes	No	)
12	If th	the answer to line 11 is "Yes," specify the information not pro	vided.					

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.

OMB No. 1210-0110

Tension benefit duaranty dor	poration	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 201	6 or fiscal pla	n year beginning 01/01/2016		and er	nding 12/3	1/2016	
A Name of plan DIALOG DIRECT WELFAR	RE BENEFITS	SPLAN			e-digit number (PI	N) <b>•</b>	501
C Plan sponsor's name as DIALOG DIRECT, INC.				46-	1570786	ation Number (	
		rning Insurance Contract  A. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car LIFE INSURANCE COMPA		IICA				D. "	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			•	ontract year
(b) EIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
23-1503749	65498	LK 750330	789		01/01/2016	6	12/31/2016
2 Insurance fee and comm descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	mount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
		19477					
3 Persons receiving comm	nissions and f	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker,	•	n commiss	ions or fees	were paid	
MERCER HEALTH & BENE	FITS		AYSPHERE CIR GO, IL 60674				
(b) Amount of sales an	d base	Fee	s and other commissior	ns paid			
commissions paid		(c) Amount	(d) Purpose				(e) Organization code
	18171	1305					3
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales an	d hase	Fee	s and other commission	other commissions paid (d) Purpose			
commissions paid		(c) Amount					(e) Organization code
For Paperwork Reduction	n Act Notice,	see the Instructions for Form 5	500.			Sched	dule A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code	
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
	_			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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P	art II							
		If more than one contract covers the same guesting information may be combined for reporting employees, the entire group of such individual.	g purposes if such con	tracts are expe	erience-rated as a uni	t. Where con	tracts	s cover individual
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	C	∏ k	Life insurance
	e X	Temporary disability (accident and sickness)	f  Long-term disabil	ity <b>q</b>	Supplemental unem	ployment <b>r</b>	า⊟ี่	Prescription drug
	iΠ	Stop loss (large deductible)	i ☐ HMO contract		PPO contract		ıΗ̈́	Indemnity contract
	m [	Other (specify)			1	·	. П.	
	∟	Other (specify)						
9	Exper	rience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)			ĺ	
		(2) Increase (decrease) in amount due but unpaid.						
	,	(3) Increase (decrease) in unearned premium rese						
	,	(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b i	Benefit charges (1) Claims paid		9b(1)		• • • • • • • • • • • • • • • • • • • •		
	(	(2) Increase (decrease) in claim reserves		9b(2)				
	(	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
	(-	(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (on	an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs						
		(D) Other expenses		9c(1)(D)				
		(E) Taxes						
		(F) Charges for risks or other contingencies		0 (4)(0)				
		(G) Other retention charges				0-(4)(11)		
		(H) Total retention	_			9c(1)(H)	<del></del>	
		(2) Dividends or retroactive rate refunds. (These a				9c(2)		
		Status of policyholder reserves at end of year: (1)	·			9d(1)	<u> </u>	
		(2) Claim reserves				9d(2)	<u> </u>	
		(3) Other reserves				9d(3) 9e		
10		nexperience-rated contracts:	include amount entere	u III IIIIe 90(2).	.)	36		
		Total premiums or subscription charges paid to ca	rrier			10a		181711
	_	If the carrier, service, or other organization incurre				100		101711
		retention of the contract or policy, other than repor	, ,		•	10b		
		cify nature of costs.	•	•				
Pa	art I\	V Provision of Information						
11	Did	the insurance company fail to provide any informa	tion necessary to comp	lete Schedule	A?	Yes	No	
		e answer to line 11 is "Yes," specify the information			<del></del>			
			•					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2016

This Form is Open to Public

		pursuant to I	ERISA section 103(a)(2)				Inspection		
For calendar plan year 20°	16 or fiscal plar	year beginning 01/01/2016		and en	iding 12/3	1/2016			
A Name of plan DIALOG DIRECT WELFA			e-digit number (PN	N) <b>•</b>	501				
C Plan sponsor's name a DIALOG DIRECT, INC.	s shown on line	e 2a of Form 5500		-	oyer Identific 1570786	ation Number	(EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance car TOTAL HEALTH CARE US									
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year		
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To		
38-3240485	12326	M60255	255		01/01/2016	6	12/31/2016		
2 Insurance fee and commodescending order of the		ation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in		
(a) Total a	amount of comr			<b>(b)</b> To	otal amount	of fees paid			
		32884							
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).					
		nd address of the agent, broker,		m commiss	ions or fees	were paid			
MERCER HEALTH & BENE	EFITS		AYSPHERE CIR GO, IL 60674						
(b) Amount of sales ar	nd base	Fed	es and other commission	ns paid			-		
commissions pai		(c) Amount	(d) Purpose			(e) Organization code			
	32884						3		
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid			
	.,	-	·			·			
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		•			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code		
For Panerwork Reduction	n Act Notice	see the Instructions for Form	5500			Sche	dule A (Form 5500) 2016		

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code	
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid		
	_			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:			<u> </u>	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa,			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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Pa	rt II	Welfare Benefit Contract Information If more than one contract covers the same grough the information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such cont	racts are e	expe	rience-rated as a unit	. Where co	ntracts	s cover individual
<b>8</b> E	Bene	efit and contract type (check all applicable boxes)	_						
á	a 🗌	Health (other than dental or vision)	Dental	C	<b>X</b>	Vision		d	Life insurance
•	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ty <b>C</b>	<b>3</b> 🗌	Supplemental unemp	loyment	h 🗶	Prescription drug
i	ıĒ	Stop loss (large deductible)	X HMO contract	ŀ	⟨□	PPO contract		ıΠ	Indemnity contract
ı	m	Other (specify)	ш		ш				·
	_	<b>_</b> _ \							
9 E	хре	erience-rated contracts:							
á	<b>a</b> P	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)					
	(	(3) Increase (decrease) in unearned premium reserv	e	9a(3)					
	(	(4) Earned ((1) + (2) - (3))					9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)					
	(	(3) Incurred claims (add (1) and (2))					9b(3)		
	(	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	n accrual basis)					_	
		(A) Commissions		9c(1)(A				_	
		(B) Administrative service or other fees		9c(1)(B				_	
		(C) Other specific acquisition costs		9c(1)(C	_			4	
		(D) Other expenses		9c(1)(D	_			_	
		(E) Taxes		9c(1)(E	_			4	
		(F) Charges for risks or other contingencies						_	
		(G) Other retention charges					0 (4)(1)		
		(H) Total retention		_			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These an	_	_			9c(2)		
		Status of policyholder reserves at end of year: (1) A	·				9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
		Dividends or retroactive rate refunds due. (Do not in	nclude amount entered	d in line 9c	(2).	)	9e		
		nexperience-rated contracts:					40-		0.450.40
	_	Total premiums or subscription charges paid to carri					10a		915348
		If the carrier, service, or other organization incurred					10b		
ç	Spec	retention of the contract or policy, other than reporte cify nature of costs.	u iii Fait i, iiile 2 abov	е, тероп а	11110	un	100		
Pa	rt I	V Provision of Information							
		I the insurance company fail to provide any information	on necessary to compl	lete Sched	lule	А?	Yes	X No	)
		he answer to line 11 is "Yes," specify the information				. Ц			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

			pursuant to E	ERISA section 103(a)(2)	).			Inspection
For calendar pla	an year 20°	16 or fiscal plar	n year beginning 01/01/2016		and er	nding 12/3	1/2016	
A Name of plar DIALOG DIREC		RE BENEFITS	PLAN			e-digit number (PI	N) <b>•</b>	501
C Plan sponsor		s shown on lin	e 2a of Form 5500		-	oyer Identific 1570786	ation Number (	EIN)
			rning Insurance Contract  . Individual contracts grouped a					
1 Coverage Info	ormation:							
(a) Name of ins			ΝΥ	_				
(b) EIN	ı	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	ontract year
(b) LIN	1	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
41-0451140		67105	EXRK	774	ļ	01/01/2016	5	12/31/2016
2 Insurance fee descending of			ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
	(a) Total a	amount of comi	-		<b>(b)</b> To	otal amount	of fees paid	
			45073					
3 Persons rece	eiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
			and address of the agent, broker,		m commiss	ions or fees	were paid	
MERCER HEALT	ΓΗ & BENI	EFITS, LLC		AYSPHERE CIRCLE GO, IL 60674				
(b) Amount o	of sales ar	nd base	Fee	es and other commissio	ns paid			
	issions pai		(c) Amount		(d) Purpos	е		(e) Organization code
		45073						3
		(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount o	of sales ar	nd base	Fee	es and other commissio	ns paid			
` '	issions pai		(c) Amount		(d) Purpos	e		(e) Organization code
Fan Damamuanlı	Poduotio	n Act Notice	con the Instructions for Form A	5500			Sahas	Iula A (Farm FF00) 2046

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:			<u> </u>	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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P	art II							
		If more than one contract covers the same group of the information may be combined for reporting purp employees, the entire group of such individual contract.	oses if such contr	acts are expe	rience-rated as a unit	. Where con	tract	s cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	Dental	с	Vision	(	l k	Life insurance
	е□		.ong-term disabilit	v <b>a</b> □	Supplemental unem	olovment <b>i</b>	า∏ี	Prescription drug
	i X		IMO contract	- =	PPO contract		브	Indemnity contract
	. <u>     </u>	Other (specify)	iivio contract	□	11 O dominado		• ⊔	macminy contract
	m _	Other (specify)						
9	Evnor	rience-rated contracts:						
	•	Premiums: (1) Amount received	[	9a(1)				
		(2) Increase (decrease) in amount due but unpaid	İ	9a(2)			}	
	,	(3) Increase (decrease) in unearned premium reserve	İ	9a(3)				
	,	(4) Earned ((1) + (2) - (3))	ı.	· · · ·		9a(4)		
	_ `	Benefit charges (1) Claims paid	ſ	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 acc	crual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)			<u> </u>	
		(C) Other specific acquisition costs		9c(1)(C)			<u> </u>	
		(D) Other expenses	•	9c(1)(D)				
		(E) Taxes		9c(1)(E)			<u> </u>	
		(F) Charges for risks or other contingencies		9c(1)(F) 9c(1)(G)				
		(G) Other retention charges(H) Total retention				9c(1)(H)		
		• •	_	_				
		(2) Dividends or retroactive rate refunds. (These amount	<u> </u>			9c(2)		
		Status of policyholder reserves at end of year: (1) Amour (2) Claim reserves	·			9d(1)		
		(3) Other reserves				9d(2) 9d(3)		
		Dividends or retroactive rate refunds due. (Do not includ				9e		
10		nexperience-rated contracts:	o arriourit oritoroa	00(2).	,			
		Total premiums or subscription charges paid to carrier				10a		976757
	_	If the carrier, service, or other organization incurred any						
		retention of the contract or policy, other than reported in I	•		•	10b		
	Spec	cify nature of costs.						
Pa	art I\	V Provision of Information						
11	Did	the insurance company fail to provide any information ne	cessary to comple	ete Schedule	A?	Yes	No	)
12	If the	ne answer to line 11 is "Yes," specify the information not p	rovided.				_	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration **Service Provider 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.

2016

OMB No. 1210-0110

This Form is Open to Public Inspection.

Ferision Benefit Guaranty Corporation	
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016	and ending 12/31/2016
A Name of plan	<b>B</b> Three-digit
DIALOG DIRECT WELFARE BENEFITS PLAN	plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
DIALOG DIRECT, INC.	46-1570786
Part I Service Provider Information (see instructions)	
or more in total compensation (i.e., money or anything else of monetary value	ne information required for <b>each person</b> who received, directly or indirectly, \$5,000 te) in connection with services rendered to the plan or the person's position with the asation for which the plan received the required disclosures, you are required to the remainder of this Part.
1 Information on Persons Receiving Only Eligible Indirect	Compensation
a Check "Yes" or "No" to indicate whether you are excluding a person from the	•
indirect compensation for which the plan received the required disclosures (s	see instructions for definitions and conditions)
b If you answered line 1a "Yes," enter the name and EIN or address of each preceived only eligible indirect compensation. Complete as many entries as not received only eligible indirect compensation.	, , , , , , , , , , , , , , , , , , , ,
(b) Enter name and EIN or address of person who p	provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who o	provided you disclosures on eligible indirect compensation
(4) =	
/b/ =	
(D) Enter name and EIN or address of person who p	provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who p	provided you disclosures on eligible indirect compensation
	<u> </u>

Schedule C (Form	5500) 2016	Page <b>2-</b> 1
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on clinible indirect compensation
(6)	Enter hame and Env or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation

Page <b>3</b> -	1	
age <b>3 -</b>	1	

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
BLUE CRO	OSS BLUE SHIELD FO	MICHIGAN				
38-206975	3					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 16 23 50 62 99	ТРА	483625	Yes X No	Yes 🛛 No 🗌	17646	Yes No X
			a) Enter name and EIN or	addraga (aga instructions)		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page <b>3</b> -	2
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).						
(a) Enter name and EIN or address (see instructions)						
					(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest
			Yes No	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No No		Yes No

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## Part I Service Provider Information (continued) If you reported on line 2 receipt of indirect compensation, other than

If you reported on line 2 receipt of indirect compensation, other than eligible indirect competer provides contract administrator, consulting, custodial, investment advisory, investment magnestions for (a) each source from whom the service provider received \$1,000 or more in information grave you a formula used to determine the indirect compensation instead of an amount and entries as needed to report the required information for each source.	anagement, broker, or recordkeepir	ng services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	,	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibilit the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibilit the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	t compensation, including any e the service provider's eligibilit the indirect compensation.

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

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Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
а	Name:		<b>b</b> EIN:		
С	Position				
d	Address		e Telephone:		
~	71001000	•	Telephone.		
	planation:				
LX	piariatiori.				
a	Name:		<b>b</b> EIN:		
С	Position				
d	Address	:	<b>e</b> Telephone:		
Ex	planation:				
a	Name:		<b>b</b> EIN:		
С	Position				
d	Address	:	<b>e</b> Telephone:		
Ex	planation:				
	Nome		b EIN:		
<u>a</u>	Name:		D EIN.		
C	Position		A.T. I.		
d	Address	;	<b>e</b> Telephone:		
Ex	planation:				
а	Name:		<b>b</b> EIN:		
С	Position				
d	Address		e Telephone:		
-					
	Funlanation				
Explanation:					