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| 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 |
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| Part I | Annual Report Identification Information | | |
| For calendar plan year 2016 or fiscal plan year beginning <u>04/01/2016</u> and ending <u>03/31/2017</u> | | | |
| A | This return/report is for: | <input type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) | |
| | <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) ____ | | |
| B | This return/report is: | <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months) | |
| C | If the plan is a collectively-bargained plan, check here. ▶ <input type="checkbox"/> | | |
| D | Check box if filing under: | <input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description) | |

| | | | |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Basic Plan Information —enter all requested information | | |
| 1a | Name of plan <u>CHILDERS OIL GROUP BENEFITS</u> | 1b | Three-digit plan number (PN) ▶ <u>503</u> |
| | | 1c | Effective date of plan <u>04/01/2016</u> |
| 2a | Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>CHILDERS OIL COMPANY, INC.</u> <u>P.O. BOX 430</u> <u>51 HIGHWAY 2034</u> <u>WHITESBURG, KY 41858-7686</u> | | 2b Employer Identification Number (EIN) <u>61-0702219</u> 2c Plan Sponsor's telephone number <u>606-633-2525</u> 2d Business code (see instructions) <u>423990</u> |

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------|--------------------------------------------------------------|
| SIGN HERE | Filed with authorized/valid electronic signature. | 10/31/2017 | TERRY ANDERSON |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | Filed with authorized/valid electronic signature. | 10/31/2017 | TERRY ANDERSON |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |
| Preparer's name (including firm name, if applicable) and address (include room or suite number) <u>TERRY C. ANDERSON</u> <u>51 HIGHWAY 2034</u> <u>WHITESBURG, KY 41858</u> | | | Preparer's telephone number <u>606-633-2525</u> |

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2016)
v. 160205

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN |
| | 3c Administrator's telephone number |
| | |
| 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name | 4b EIN 4c PN |
| 5 Total number of participants at the beginning of the plan year | 5 138 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). | |
| a(1) Total number of active participants at the beginning of the plan year..... | 6a(1) 138 |
| a(2) Total number of active participants at the end of the plan year | 6a(2) 151 |
| b Retired or separated participants receiving benefits..... | 6b 0 |
| c Other retired or separated participants entitled to future benefits | 6c 0 |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | 6d 151 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | 6e 0 |
| f Total. Add lines 6d and 6e | 6f 151 |
| g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | 6g |
| h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested | 6h |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)..... | 7 |

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E

| | |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 9a Plan funding arrangement (check all that apply) | 9b Plan benefit arrangement (check all that apply) |
| (1) <input checked="" type="checkbox"/> Insurance | (1) <input checked="" type="checkbox"/> Insurance |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts |
| (3) <input type="checkbox"/> Trust | (3) <input type="checkbox"/> Trust |
| (4) <input checked="" type="checkbox"/> General assets of the sponsor | (4) <input checked="" type="checkbox"/> General assets of the sponsor |

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

a Pension Schedules

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

b General Schedules

- (1)** ☐ **H** (Financial Information)
- (2)** ☐ **I** (Financial Information – Small Plan)
- (3)** ☒ **4** **A** (Insurance Information)
- (4)** ☒ **C** (Service Provider Information)
- (5)** ☐ **D** (DFE/Participating Plan Information)
- (6)** ☐ **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

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| SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small> | Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | OMB No. 1210-0110 <hr/> 2016 <hr/> This Form is Open to Public Inspection |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|

For calendar plan year 2016 or fiscal plan year beginning **04/01/2016** and ending **03/31/2017**

| | | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| A Name of plan CHILDERS OIL GROUP BENEFITS | B Three-digit plan number (PN) | 503 |
| | | |
| C Plan sponsor's name as shown on line 2a of Form 5500 CHILDERS OIL COMPANY, INC. | D Employer Identification Number (EIN) 61-0702219 | |

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

1 Coverage Information:

(a) Name of insurance carrier
ANTHEM HEALTH PLANS OF KENTUCKY, INC.

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
| | | | | (f) From | (g) To |
| 61-1237516 | 95120 | 001008834 | 132 | 04/01/2016 | 03/31/2017 |

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

| | |
|-----------------------------------------------------|-------------------------------------------|
| (a) Total amount of commissions paid 1673 | (b) Total amount of fees paid 0 |
|-----------------------------------------------------|-------------------------------------------|

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ENERGY INSURANCE AGENCY, INC. P.O. BOX 55268
 LEXINGTON, KY 40555

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1255 | 0 | | 3 |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
COMPREHENSIVE BUSINESS INS SOLUTION P.O. BOX 1485
 CORBIN, KY 40702

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 417 | 0 | | 3 |

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end **4****5** Current value of plan's interest under this contract in separate accounts at year end..... **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier**6b****c** Premiums due but unpaid at the end of the year**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount**6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year **7b****c** Additions: (1) Contributions deposited during the year**7c(1)**

(2) Dividends and credits.....

7c(2)

(3) Interest credited during the year.....

7c(3)

(4) Transferred from separate account

7c(4)

(5) Other (specify below)

7c(5)

▶

(6) Total additions **7c(6)****d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d****e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

7e(1)

(2) Administration charge made by carrier.....

7e(2)

(3) Transferred to separate account

7e(3)

(4) Other (specify below)

7e(4)

▶

(5) Total deductions **7e(5)****f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|--|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | 9a(4) | |
| b Benefit charges (1) Claims paid | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | 9b(3) | |
| (4) Claims charged | | 9b(4) | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | | |
| (C) Other specific acquisition costs | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | | |
| (G) Other retention charges | 9c(1)(G) | | |
| (H) Total retention | | 9c(1)(H) | |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) | |
| (2) Claim reserves | | 9d(2) | |
| (3) Other reserves | | 9d(3) | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e | |

10 Nonexperience-rated contracts:

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|
| a Total premiums or subscription charges paid to carrier | 10a | 17167 |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. | 10b | |

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

| | | |
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| SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small> | Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | OMB No. 1210-0110 <hr/> 2016 <hr/> This Form is Open to Public Inspection |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|

For calendar plan year 2016 or fiscal plan year beginning **04/01/2016** and ending **03/31/2017**

| | | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| A Name of plan CHILDERS OIL GROUP BENEFITS | B Three-digit plan number (PN) | 503 |
| | | |
| C Plan sponsor's name as shown on line 2a of Form 5500 CHILDERS OIL COMPANY, INC. | D Employer Identification Number (EIN) 61-0702219 | |

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

1 Coverage Information:

(a) Name of insurance carrier
ANTHEM LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
| | | | | (f) From | (g) To |
| 35-0980405 | 61069 | 00235242 | 159 | 03/01/2016 | 03/31/2017 |

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

| | |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 782 | 0 |

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ENERGY INSURANCE AGENCY, INC. **P.O. BOX 55268**
LEXINGTON, KY 40555

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 582 | 0 | | 3 |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
COMPREHENSIVE BUSINESS INS SOLUTION **P.O. BOX 1485**
CORBIN, KY 40702

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 200 | 0 | | 3 |

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

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

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

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

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

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

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| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
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| | | | |

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

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|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end **4****5** Current value of plan's interest under this contract in separate accounts at year end..... **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier**6b****c** Premiums due but unpaid at the end of the year**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount**6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year **7b****c** Additions: (1) Contributions deposited during the year**7c(1)**

(2) Dividends and credits.....

7c(2)

(3) Interest credited during the year.....

7c(3)

(4) Transferred from separate account

7c(4)

(5) Other (specify below)

7c(5)

▶

(6) Total additions **7c(6)****d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d****e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

7e(1)

(2) Administration charge made by carrier.....

7e(2)

(3) Transferred to separate account

7e(3)

(4) Other (specify below)

7e(4)

▶

(5) Total deductions **7e(5)****f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|--|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | 9a(4) | |
| b Benefit charges (1) Claims paid | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | 9b(3) | |
| (4) Claims charged | | 9b(4) | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | | |
| (C) Other specific acquisition costs | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | | |
| (G) Other retention charges | 9c(1)(G) | | |
| (H) Total retention | | 9c(1)(H) | |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) | |
| (2) Claim reserves | | 9d(2) | |
| (3) Other reserves | | 9d(3) | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e | |

10 Nonexperience-rated contracts:

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|------|
| a Total premiums or subscription charges paid to carrier | 10a | 5216 |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. | 10b | |

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small> | Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | OMB No. 1210-0110 <hr/> 2016 <hr/> This Form is Open to Public Inspection |
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For calendar plan year 2016 or fiscal plan year beginning **04/01/2016** and ending **03/31/2017**

| | | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| A Name of plan CHILDERS OIL GROUP BENEFITS | B Three-digit plan number (PN) ► | 503 |
| | | |
| C Plan sponsor's name as shown on line 2a of Form 5500 CHILDERS OIL COMPANY, INC. | D Employer Identification Number (EIN) 61-0702219 | |

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

1 Coverage Information:

(a) Name of insurance carrier

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
| | | | | (f) From | (g) To |
| 57-0144607 | 62049 | E3888807 | 258 | 04/01/2016 | 03/31/2017 |

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

| | |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 25676 | 18372 |

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

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

THE HINTON AGENCY LLC
121 EAST ELECTRIC AVENUE
FLEMINGSBURG, KY 41041

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 9604 | 1182 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

EMPLOY BENEFIT SOLUTIONS, LLC
2785 MAYFIELD HWY
BENTON, KY 42025

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 154 | 21 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

LESLIE ANN FEATHERLY

3022 HELENA ROAD
FLEMMINGSBURG, KY 41041

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 8122 | 2697 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

NORMA J. DAVIS

269 RUFFIAN TRAIL
CORBIN, KY 40701

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 42 | 2 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

SHANA A COOPER

407 WICKFIELD DRIVE
LOUISVILLE, KY 40245

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 8 | 0 | | 3 |

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

MARY DUFF

1005 RICHMOND ROAD
LEXINGTON, KY 40502

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 346 | 1 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

SHAWNALINE JACKSON

421 HANSON STREET
PARIS, KY 40361

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1923 | 558 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

DEE ANN SLADE

104 POTOMAC COURT
FRANKFORT, KY 40601

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 121 | 0 | | 3 |

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

SARAH BARDELL

2132 LIGHTHOUSE LANE
LEXINGTON, KY 40509

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1277 | 231 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

VANCE NEAL MICHAEL

1005 RICHMOND ROAD
LEXINGTON, KY 40502

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 143 | 0 | | 3 |

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

BOBBIE J. WHITAKER

2530 SCOTTSVILLE ROAD
BOWLING GREEN, KY 42014

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 7 | 1 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

BOBBIE J. WHITAKER

2530 SCOTTSVILLE ROAD
BOWLING GREEN, KY 42014

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 7 | 1 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

BOBBIE J. WHITAKER

2530 SCOTTSVILLE ROAD
BOWLING GREEN, KY 42014

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 7 | 1 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

ANNE OWENS

1516 DEER LAKE DRIVE
LEXINGTON, KY 40515

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 160 | 0 | | 3 |

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

BART GAUNT

4021 ST GERMAINE CT
LOUISVILLE, KY 40207

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 2 | 0 | | 3 |

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

ANDREW THOMAS DONOHOO

515 SHADY LANE
MURRAY, KY 40271

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 95 | 4 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

DANNY KYLE PRATER

P.O. BOX 281
TOLLESBORO, KY 41189

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 185 | 232 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

ANY BOWMAN

6214 SULPHUR WELL
NICHOLASVILLE, KY 40356

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 372 | 0 | | 3 |

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

CHRISTINA STEPHENSON

344 MEMORY LANE
LEXINGTON, KY 40502

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 716 | 119 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

ROBERT BERNARD SCHMUTTE

851 CHARWOOD DRIVE
LEXINGTON, KY 40515

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1399 | 152 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

SUZANNE BRATTON TUCKER

P.O. BOX 22518
LEXINGTON, KY 40522

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 75 | 0 | | 3 |

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

PENA ENTERPRISES, INC

3288 SWEET CLOVER LANE
LEXINGTON, KY 40509

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 64 | 9 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

VICKIE E LEWIS

6558 STOVALL RD
CAVE CITY, KY 42127

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 85 | 2 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

KATHERINE MCCORMICK

P.O. BOX 95
DUNBAR, WV 25064

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 63 | 0 | | 3 |

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

MOUNTAIN STATE EMPLOYEE BENEFITS, L

103 6TH AVE
ST SLBANS, WV 25177

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 9 | 0 | | 3 |

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

REGINA SCHMUTTE

851 CHARWOOD DR
LEXINGTON, KY 40515

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 588 | 4163 | UNKNOWN - NOT SPECIFIED BY CARRIER | 3 |

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end **4****5** Current value of plan's interest under this contract in separate accounts at year end..... **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier**6b****c** Premiums due but unpaid at the end of the year**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount**6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year**7b****c** Additions: (1) Contributions deposited during the year**7c(1)**

(2) Dividends and credits.....

7c(2)

(3) Interest credited during the year.....

7c(3)

(4) Transferred from separate account

7c(4)

(5) Other (specify below)

7c(5)

▶

(6) Total additions

7c(6)**d** Total of balance and additions (add lines **7b** and **7c(6)**)**7d****e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

7e(1)

(2) Administration charge made by carrier.....

7e(2)

(3) Transferred to separate account

7e(3)

(4) Other (specify below)

7e(4)

▶

(5) Total deductions

7e(5)**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**).....**7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|--|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | 9a(4) | |
| b Benefit charges (1) Claims paid | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | 9b(3) | |
| (4) Claims charged | | 9b(4) | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | | |
| (C) Other specific acquisition costs | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | | |
| (G) Other retention charges | 9c(1)(G) | | |
| (H) Total retention | | 9c(1)(H) | |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) | |
| (2) Claim reserves | | 9d(2) | |
| (3) Other reserves | | 9d(3) | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e | |

10 Nonexperience-rated contracts:

| | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|
| a Total premiums or subscription charges paid to carrier | 10a | 92771 |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. | 10b | |

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☒ Yes ☐ No

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

REASON FOR FEES PAID

| | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation | Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | OMB No. 1210-0110 2016 This Form is Open to Public Inspection |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|

For calendar plan year 2016 or fiscal plan year beginning 04/01/2016 and ending 03/31/2017

| | |
|---------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| A Name of plan CHILDERS OIL GROUP BENEFITS | B Three-digit plan number (PN) ▶ 503 |
| C Plan sponsor's name as shown on line 2a of Form 5500 CHILDERS OIL COMPANY, INC. | D Employer Identification Number (EIN) 61-0702219 |

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

1 Coverage Information:

(a) Name of insurance carrier
COMPANION LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
| | | | | (f) From | (g) To |
| | | | 195 | 04/01/2016 | 03/31/2017 |

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

| | |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| | |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|--|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | 9a(4) | |
| b Benefit charges (1) Claims paid | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | 9b(3) | |
| (4) Claims charged | | 9b(4) | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | | |
| (C) Other specific acquisition costs | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | | |
| (G) Other retention charges | 9c(1)(G) | | |
| (H) Total retention | | 9c(1)(H) | |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) | |
| (2) Claim reserves | | 9d(2) | |
| (3) Other reserves | | 9d(3) | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e | |

10 Nonexperience-rated contracts:

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|
| a Total premiums or subscription charges paid to carrier | 10a | 280442 |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. | 10b | |

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☒ Yes ☐ No

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

NO COMPANY IDENTIFICATION, NO POLICY IDENTIFICATION, NAIC CODE, DETAILS FOR SCHEDULE A PART II

| | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation | 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. | OMB No. 1210-0110 |
| | | 2016 |
| | | This Form is Open to Public Inspection. |

For calendar plan year 2016 or fiscal plan year beginning **04/01/2016** and ending **03/31/2017**

| | | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| A Name of plan CHILDERS OIL GROUP BENEFITS | B Three-digit plan number (PN) ► | 503 |
| | | |
| C Plan sponsor's name as shown on line 2a of Form 5500 CHILDERS OIL COMPANY, INC. | D Employer Identification Number (EIN) 61-0702219 | |

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| Part I | Service Provider Information (see instructions) |
|---------------|--------------------------------------------------------|

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

| | |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation | |
| ARC ADMINISTRATORS | 333 W. VINE STREET SUITE 1650 LEXINGTON, KY 40507 |
| 61-1237516 | |

| |
|-------------------------------------------------------------------------------------------------------------------|
| (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

COMPREHENSIVE BUSINESS INS SOLUTION

P.O. BOX 1485
CORBIN, KY 40702

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 70 | BROKER | 38980 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

ARC ADMINISTRATORS

333 W. VINE STREET
SUITE 1650
LEXINGTON, KY 40507

61-1237516

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 12 15 49 | THIRD PARTY ADMINISTRATOR | 78996 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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 | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

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

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|--------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------|
| | | |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
| | | |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
| | | |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
| | | |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
| | | |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
| | | |

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

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|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |
| | |

Explanation:

| | |
|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |
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Explanation:

| | |
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| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |
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Explanation:

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

Explanation:

| | |
|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |
| | |

Explanation: