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

2017

This Form is Open to Public Inspection

Part I An	nnual Report Ide	ntification Information					
For calendar pla	an year 2017 or fiscal	plan year beginning 01/01/2017	and ending 12/31/2017	•			
A This return/re	eport is for:	a multiemployer plan	a multiple-employer plan (Filers checking this participating employer information in accorda			ns.)	
		x a single-employer plan	a DFE (specify)				
B This return/re	eport is:	the first return/report	the final return/report				
		an amended return/report	a short plan year return/report (less than 12 n	nonths)		
C If the plan is	a collectively-bargain	ned plan, check here			• [
D Check box if	filing under:	Form 5558	automatic extension	the	e DFVC program		
		special extension (enter description	n)				
Part II Ba	Part II Basic Plan Information—enter all requested information						
1a Name of plan				1b	Three-digit plan number (PN) ▶	501	
PHYSICIANS (PHYSICIANS GROUP SERVICES PA DBA FAMILY MEDICAL CENTERS WELFARE BENEFITS PLAN			1c	Effective date of pla	an	
Mailing add City or town	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)					2b Employer Identification Number (EIN) 59-3591435	
	ROUP SERVICES PA	A		2c	Plan Sponsor's tele	phone	
FAMILY MEDICA	AL CENTERS				number 904-282-6331		
			JNTY ROAD 218 IURG, FL 32068-5708	2d	Business code (see instructions) 621111)	

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. Signature of plan administrator	05/22/2018 Date	ZANDA CHANDLER Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	05/22/2018	ZANDA CHANDLER
	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

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

Form 5500 (2017) v. 170203

	Form 5500 (2017)	Pac	ge 2		
3a	Plan administrator's name and address X Same as Plan Sponsor				r's EIN
				3c Administrato number	r's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin			4b EIN	
a c	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name Plan Name	n the last returi	n/report:	4d PN	
5	Total number of participants at the beginning of the plan year			5	431
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	l (welfare plans	s complete only lines 6a(1),		
а(1) Total number of active participants at the beginning of the plan year			6a(1)	431
a((2) Total number of active participants at the end of the plan year			6a(2)	402
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			6c	2
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	404
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits.		6e	
f	Total. Add lines 6d and 6e .			6f	404
g	Number of participants with account balances as of the end of the plan year (complete this item)			6g	
h	Number of participants who terminated employment during the plan year with less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer	plans complete this item)	•	
8a b	If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature code. 4A 4B 4D 4E 4F 4H 4L				
9a	Plan funding arrangement (check all that apply) (1)	9b Plan bei (1)	nefit arrangement (check all th	nat apply)	
	(2) Code section 412(e)(3) insurance contracts (3) Trust	(2)	Code section 412(e)(3) Trust	insurance contract	ts
10	(4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are at	(4)	General assets of the s	•	inetructions\
			vnere indicated, enter the num	ibei allached. (506	; ແາຣແພບແບກຣ)
а	Pension Schedules (1) R (Retirement Plan Information)	(1)	H (Financial Infor	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	mation – Small Plar	า)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) (4)	X 12 A (Insurance Info	ŕ	

(5)

(6)

SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(3)

D (DFE/Participating Plan Information)

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.)						
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 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.)						
Rece	ipt Confirmation Code					

Form 5500 (2017)

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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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017					and ending 12/31/2017			
A Name of plan PHYSICIANS GROUP SERVICES PA DBA FAMILY MEDICAL CENTERS WELFARE BENEFITS PLAN				B Three-digit plan number (PN) 501				
C Plan sponsor's name a		e 2a of Form 5500		-	oyer Identification Number	(EIN)		
PHYSICIANS GROUP SE	ERVICES PA			59-	3591435			
		ning Insurance Contrac . Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca		H AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or o	ontract year		
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To		
23-1503749	65498	FLX967210	402	2	01/01/2017	12/31/2017		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, brokers, and c	other persons in		
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fees paid			
		15346						
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			
JEAN WILLIAMS III		7077 E STE 3	BONNEVAL RD					
			SONVILLE, FL 32216					
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		_		
commissions pai		(c) Amount		(d) Purpose		(e) Organization code		
	293					3		
	(a) Name a	nd address of the agent, broker	or other person to who	m commiss	sions or fees were paid			
MFB FINANCIAL INC	(2)	1200 F	PLANTATION ISLAND D					
	ST. AUGUSTINE, FL 32080							
(h) Amount of sales or	nd hase	Fe	es and other commission	ns paid				
(b) Amount of sales and base commissions paid (c		(c) Amount	(d) Purpose		e	(e) Organization code		
	1553					3		
For Paperwork Reductio	n Act Notice,	see the Instructions for Form	5500.		Sche	dule A (Form 5500) 2017		

Schedule A (Form 5500) 20	017	Page 2 – 1	
00.1000.10 (1 0.111 0000) 20	<u></u>	. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
(a) Name	and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
HARDEN & ASSOCIATES INC	SI	01 RIVERSIDE AVE FE 1000 CCKSONVILLE, FL 32202	
	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
7500			3
(a) Name	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
(a) Name	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
(a) Name	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	(e) Organization code
			I

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

(c) Amount

(b) Amount of sales and base commissions paid

Fees and other commissions paid

(d) Purpose

(e) Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			. \Box		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

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P	art	Welfare Benefit Contract Information	ation				
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting purposes if such cont	racts are exp	erience-rated as a unit	. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	с	Vision		d X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	ty g	Supplemental unem	olovment	h Prescription drug
	: [<u>=</u>	·	=	Sidymont	<u> </u>
	' <u> </u>	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
_	_						
9	•	erience-rated contracts:		0=(4)			_
	a	Premiums: (1) Amount received		9a(1) 9a(2)			_
		(2) Increase (decrease) in amount due but unpaid(3) Increase (decrease) in unearned premium res					
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid				1 04(+)	
		(2) Increase (decrease) in claim reserves		(-)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs					
		(D) Other expenses					
		(E) Taxes					_
		(F) Charges for risks or other contingencies.		9C(1)(F)			_
		(G) Other retention charges				00(4)(U)	<u> </u>
		(H) Total retention				9c(1)(H)	1
	لہ	(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1				9d(1)	
		(2) Claim reserves				9d(2) 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	
10		nexperience-rated contracts:	of include amount entered	2 111 1111C 3C(2)		1 30	
	а	Total premiums or subscription charges paid to o	arrier			10a	60354
	b	If the carrier, service, or other organization incurr					
		retention of the contract or policy, other than repo				10b	
	Spe	cify nature of costs.					
Р	art l	V Provision of Information					
		I the insurance company fail to provide any inform	nation necessary to compl	ete Schedule	A?X	Yes	No
		ne answer to line 11 is "Yes," specify the informati	•		··		<u></u>

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

2017

		pursuant to E	:RISA section 103(a)(2).	-			Inspection
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017					ding 12/3	31/2017	
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	S WELFARE		e-digit number (PN	N) •	501		
C Plan sponsor's name a PHYSICIANS GROUP SE		e 2a of Form 5500			yer Identific 3591435	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca LIFE INSURANCE COMPA		H AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
23-1503749	65498	LK 964951	198		01/01/2017	7	12/31/2017
2 Insurance fee and coming descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of comr	missions paid		(b) To	tal amount	of fees paid	
		14874					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
MFB FINANCIAL INC			LANTATION ISLAND D GUSTINE, FL 32080	R S STE 2	10		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpose			(e) Organization code
	4127						3
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
HARDEN & ASSOCIATES	INC	STE 10	/ERSIDE AVE 00 ONVILLE, FL 32202				
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	10748						3
For Panerwork Reduction	n Act Notice s	see the Instructions for Form 5	500			Scher	lule A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

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P	art l		-				
		If more than one contract covers the same granthe information may be combined for reporting employees, the entire group of such individual.	g purposes if such contr	acts are exp	erience-rated as a uni	t. Where co	ontracts cover individual
8	Bene	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	еĪ		f X Long-term disability	y g	Supplemental unem	nlovment	h Prescription drug
	. L			~ _	=	pioymoni	
	'	Stop loss (large deductible)	HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
		erience-rated contracts:	Г	2 (1)			_
		Premiums: (1) Amount received	l -	9a(1)			_
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			_
		(3) Increase (decrease) in unearned premium rese	_	9a(3)		00(4)	
	_	(4) Earned ((1) + (2) - (3))	Г			. 9a(4)	
	b	Benefit charges (1) Claims paid	F	9b(1) 9b(2)			_
		(2) Increase (decrease) in claim reserves				. 9b(3)	
		(4) Claims charged				9b(4)	
		Remainder of premium: (1) Retention charges (on				35(4)	
		(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	F	9c(1)(D)			_
		(E) Taxes	le l				_
		(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 a	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (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	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			. 10a	116404
	_	If the carrier, service, or other organization incurre retention of the contract or policy, other than repor ecify nature of costs.				. 10b	
_							
Pa	art I	IV Provision of Information					
11	Dic	d the insurance company fail to provide any informa	tion necessary to comple	ete Schedule	A?X	Yes	No
12	1f +l	the answer to line 11 is "Vee " anseify the information	n 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		pursuant to I	=1(10A 3cction 103(a)(2)	•		Inspection	
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	nding 12/31/2017		
A Name of plan PHYSICIANS GROUP SERVICES PA DBA FAMILY MEDICAL CENTER BENEFITS PLAN			RS WELFARE		e-digit number (PN)	501	
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	oyer Identification Numbe	r (EIN)	
PHYSICIANS GROUP SE	RVICES PA			59-	3591435		
		ning Insurance Contract . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
LIFE INSURANCE COMPA		H AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To	
23-1503749	65498	OK 968717	402		01/01/2017	12/31/2017	
2 Insurance fee and come descending order of the		ation. Enter the total fees and tot	al commissions paid. Li	st in line 3	the agents, brokers, and	other persons in	
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fees paid		
		1232					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
<u> </u>		nd address of the agent, broker,			sions or fees were paid		
MFB FINANCIAL INC			PLANTATION ISLAND D JGUSTINE, FL 32202	R S STE 2	210		
(h) Amount of color or	d boos	Fee	es and other commission	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code	
	204					3	
	(a) Name a	nd address of the agent, broker,	, or other person to whor	n commiss	sions or fees were paid		
HARDEN & ASSOCIATES	INC	STE 10	VERSIDE AVE 000 SONVILLE, FL 32202				
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pai		(c) Amount	((d) Purpos	е	(e) Organization code	
	1027					3	
For Paperwork Reductio	n Act Notice,	see the Instructions for Form !	5500.		Sch	edule A (Form 5500) 2017 v. 170203	

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

ı	Page	4

F	art l	II Welfare Benefit Contract Inform	ation					
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same than the coverage of the same that the coverage of the coverage	ting purposes if such cont	racts are exp	périence-rated as a un	it. Where co	ontracts cover indiv	
8	Bene	efit and contract type (check all applicable boxes)			·		·	
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insuran	ce
	_	Temporary disability (accident and sickness)	f ☐ Long-term disabili	<u>_</u>	Supplemental unen	anla umant	h Prescription	
	e [<u>.</u>				ipioyment		-
	' [Stop loss (large deductible)	j HMO contract	κ	PPO contract		I Indemnity co	ontract
	m	Other (specify) ACCIDENTAL DEATH						
_								
9	Expe	rience-rated contracts:			T		_	
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpai						
		(3) Increase (decrease) in unearned premium res				0=(4)		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid(2) Increase (decrease) in claim reserves		/->			_	
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		- (()(-)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes						
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention)	
	_	(2) Dividends or retroactive rate refunds. (These	_					
	d	Status of policyholder reserves at end of year: (*)	•			• • •		
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				• • •		
10		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	a in line 9c(2	() .)	9e		
10		nexperience-rated contracts: Total premiums or subscription charges paid to	carrior			10a		021
	_					10a		821
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	, ,		•	10b		
	Spe	cify nature of costs.	o a, 2 a	o, .opo				
P	art I	V Provision of Information						
11		the insurance company fail to provide any inform	nation necessary to comp	lete Schedul	e A?X	Yes	No	
		ne answer to line 11 is "Yes," specify the informat		2.0 001100001		1		
		a to mile i i io, opoony trio initornia	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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		pursuant to i	LINIOA 3000011 103(a)(2)	•		Inspection
For calendar plan year 20	17 or fiscal plan	year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	ERVICES PA D	BA FAMILY MEDICAL CENTER	RS WELFARE		e-digit number (PN)	501
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	oyer Identification Number	· (EIN)
PHYSICIANS GROUP SE	RVICES PA			59-	-3591435	
		ning Insurance Contrac . Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
LIFE INSURANCE COMPA		H AMERICA				
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	(g) To
23-1503749	65498	VDT962067	191		01/01/2017	12/31/2017
2 Insurance fee and composite descending order of the		ation. Enter the total fees and tot	tal commissions paid. Li	st in line 3	the agents, brokers, and	other persons in
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fees paid	
		9499		, ,	•	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	persons).		
•		nd address of the agent, broker,			sions or fees were paid	
MFB FINANCIAL INC			PLANTATION ISLAND D JGUSTINE, FL 32080	R S STE 2	210	
(In) Amount of color or	d b	Fee	es and other commission	ns paid		
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code
	1656					3
	(a) Name a	nd address of the agent, broker,	, or other person to whor	n commiss	sions or fees were paid	
HARDEN & ASSOCIATES	INC	STE 10	VERSIDE AVE 000 SONVILLE, FL 32202			
(b) Amount of sales ar	nd base	Fee	es and other commissior	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code
	7843					3
For Paperwork Reductio	n Act Notice, s	see the Instructions for Form	5500.		Scho	edule A (Form 5500) 2017 v. 170203

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			. \Box		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

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P	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	group of employees of the ing purposes if such cont	racts are e	expe	rience-rated as a unit	. Where co	ontracts cover individual	_
8	Don		dai contracts with each ca	anner may	ו שמ	ireated as a unit for po	iiposes oi i	шіз тероп.	_
0	Ī	efit and contract type (check all applicable boxes)	⊾ □ .					. بن الم	
	а	Health (other than dental or vision)	b Dental			Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty C	9 🗌	Supplemental unemp	loyment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	ŀ	k 🗌	PPO contract		I Indemnity contract	
	m	Other (specify)	_					_	
9	Ехр	erience-rated contracts:							Ī
		Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid	l	• •					
		(3) Increase (decrease) in unearned premium res							
		(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 (o	n an accrual basis)						
		(A) Commissions		9c(1)(A	(۱				
		(B) Administrative service or other fees		9c(1)(B					
		(C) Other specific acquisition costs		9c(1)(C	_				
		(D) Other expenses			_				
		(E) Taxes		- ///-					
		(F) Charges for risks or other contingencies							
		(G) Other retention charges					- (1) (1)		
		(H) Total retention	_				9c(1)(H)	_
		(2) Dividends or retroactive rate refunds. (These	—	_			9c(2)		_
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		_
		(2) Claim reserves					9d(2)		_
		(3) Other reserves					9d(3)		_
4.0	<u>е</u>	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c	(2).)	9e		
10	_	nexperience-rated contracts:					100	0000	_
	a	Total premiums or subscription charges paid to c					10a	6332	it.
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,			•	10b		
	Spe	cify nature of costs.	nted in rait i, line 2 abov	c, report e	11110	unt	100		-
D	art	IV Provision of Information							-
				. 6 :		10	Voc	П мо	_
		d the insurance company fail to provide any inform		ete Sched	alut	A?	Yes	No	_
12	. If t	he answer to line 11 is "Yes," specify the informati	on 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

2017

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017								
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	ERVICES PA D	BA FAMILY MEDICAL CENTERS	S WELFARE	B Three	e-digit number (PN	N) •	501	
C Plan sponsor's name as shown on line 2a of Form 5500 PHYSICIANS GROUP SERVICES PA D Employer Identification Number (Ell 59-3591435						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		DA						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
59-2015694	98167	70953	19)	01/01/2017	7	09/30/2017	
	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								
		8919						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
		nd address of the agent, broker,			ions or fees	were paid		
HARDEN & ASSOCIATES			/ERSIDE AVE STE 100 ONVILLE, FL 32202-49					
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pa	id 8919	(c) Amount		(d) Purpose	Э		(e) Organization code	
					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	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

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Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individual.	ting purposes if such conti	racts are exp	perience-rated as a ur	nit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-		-	i
	а	X Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	L I	Temporary disability (accident and sickness)	f Long-term disabilit	<u>L</u>	Supplemental uner		h X Prescription drug
	e			- 5		прюуттетт	
	1	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Exp	erience-rated contracts:			I		
	а	Premiums: (1) Amount received		9a(1)		222986	<u>; </u>
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res	•			1	
		(4) Earned ((1) + (2) - (3))			I		222986
	b	Benefit charges (1) Claims paid				177564	+
		(2) Increase (decrease) in claim reserves				T	
		(3) Incurred claims (add (1) and (2))					177564
	_	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o		0 (4)(4)			_
		(A) Commissions		9c(1)(A)		8919	}
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)		00447	_
		(D) Other expenses		0 (4)(5)		28447	
		(E) Taxes(F) Charges for risks or other contingencies				1366	
		(G) Other retention charges				6690	<u>) </u>
		(H) Total retention	•			9c(1)(H)	45422
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1	_				
	u	(2) Claim reserves				9d(1)	
		(3) Other reserves					
	е	Dividends or retroactive rate refunds due. (Do no					
10	_	pnexperience-rated contracts:	st molade amount entered	2 III IIII C 30(L	<i>J</i> .,		
	а	Total premiums or subscription charges paid to c	arrier			10a	
	b	If the carrier, service, or other organization incurr					
		retention of the contract or policy, other than repo	, ,		•	10b	
	Spe	ecify nature of costs.	·	•			
_							
P	art				r	7	
11	Di	d the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	e A?	Yes	X No
12	lf t	he answer to line 11 is "Yes," specify the informati	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

2017

pursuant to ERISA section 103(a)(2).						Inspection		
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017								
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	ERVICES PA D	BA FAMILY MEDICAL CENTERS	S WELFARE	B Thre	e-digit number (PN	N) •	501	
C Plan sponsor's name as shown on line 2a of Form 5500 PHYSICIANS GROUP SERVICES PA D Employer Identification Number (EIN) 59-3591435						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		DA						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
59-2403696	95089	70953	231		01/01/2017	7	09/30/2017	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of comr			(b) To	otal amount	of fees paid		
		57623						
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).				
		nd address of the agent, broker,			ions or fees	were paid		
HARDEN & ASSOCIATES			/ERSIDE AVE STE 100 ONVILLE, FL 32202	00				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	
	57632						3	
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
		V .	·			·		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

ı	Page	4

P	Part III Welfare Benefit Contract Information								
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting purposes if such conti	racts are exp	perience-rated as a uni	it. Where co	ontracts cover individual	,	
8	Ben	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance		
	е	Temporary disability (accident and sickness)	f Long-term disabilit	L	Supplemental unem	nlovmont	h Prescription drug		
					_	ipioyment			
	וי	Stop loss (large deductible)	j X HMO contract	ĸ	PPO contract		I Indemnity contract		
	m	Other (specify)							
_									
9		erience-rated contracts:	į		T				
	а	Premiums: (1) Amount received		9a(1)		1440574	4		
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium res	•	9a(3)		- (0)	44.	1057	
	L	(4) Earned ((1) + (2) - (3))			 T	9a(4)		10574	
	b	Benefit charges (1) Claims paid		9b(1)		1157933	3		
		(2) Increase (decrease) in claim reserves				01 (0)	445	7000	
		(3) Incurred claims (add (1) and (2))				9b(3)	118	57933	
	_	(4) Claims charged				9b(4)			
	С	Remainder of premium: (1) Retention charges (c		0=(4)(A)	T	F7000			
		(A) Commissions		9c(1)(A)		57623	3		
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)					
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)		404000	_		
		(E) Taxes		0.(4)(5)		181800			
		(F) Charges for risks or other contingencies.				0 43217			
		(G) Other retention charges				43217			
		(H) Total retention	•			9c(1)(H)) 28	32640	
		(2) Dividends or retroactive rate refunds. (These							
	d	Status of policyholder reserves at end of year: (1	_	_					
	u	(2) Claim reserves				9d(2)			
		(3) Other reserves							
	е	Dividends or retroactive rate refunds due. (Do n							
10	_	onexperience-rated contracts:	<u> </u>		, , ,	,			
	а	Total premiums or subscription charges paid to o	arrier			10a			
	b	If the carrier, service, or other organization incurr							
	~	retention of the contract or policy, other than repe	, ,		•	10b			
	Spe	ecify nature of costs.	·	•					
Р	art	IV Provision of Information							
11	Di	d the insurance company fail to provide any inform	nation necessary to compl	ete Schedule	e A?	Yes	X No		
		he answer to line 11 is "Yes," specify the informat							
_		/ - /	•						

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

2017

pursuant to ERISA section 103(a)(2).						Inspection		
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017								
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	ERVICES PA D	BA FAMILY MEDICAL CENTER	S WELFARE	B Three	e-digit number (PN	N) •	501	
C Plan sponsor's name as shown on line 2a of Form 5500 PHYSICIANS GROUP SERVICES PA D Employer Identification Number (EIN) 59-3591435						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		DA						
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
59-2015694	98167	70953	19)	10/01/2017	7	12/31/2017	
	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 a	amount of comr			(b) To	otal amount	of fees paid		
		2995						
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		
MFB FINANCIAL INC			LANTATION ISLAND E GUSTINE, FL 32080	OR S STE 2	10			
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	
	2995						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	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	A 4 NI 41			·	· ·			

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	idual contrac	ts 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 er			5	
		tracts With Allocated Funds:				
•	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	b	Premiums paid to carrier		[6b	
	C	Premiums due but unpaid at the end of the year		ŀ	6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ite participati	on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(*) 🗋 3***********************************				
	b	Palance at the and of the provious year		Ī	7b	
	C	Balance at the end of the previous year	7c(1)		70	
	C	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	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	
	е	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	

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P	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 wi	ith each carrier ma	ay be	treated as a unit f	for purposes of the	nis report.	
8	Ben	nefit and contract type (check all applicable boxes)			_		_	
	a	Health (other than dental or vision)		С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness) f Long-ter	rm disability	g	Supplemental u	nemployment	h X Prescription drug	
	ίĪ	Stop loss (large deductible) j HMO col	ntract	k	PPO contract		I Indemnity contract	
	m	Other (specify)		_	_			
	L							
9	Expe	perience-rated contracts:						
		Premiums: (1) Amount received	9a(1	1)		74882	1	
		(2) Increase (decrease) in amount due but unpaid					1	
		(3) Increase (decrease) in unearned premium reserve						
		(4) Earned ((1) + (2) - (3))				9a(4)	7488	
	b	Benefit charges (1) Claims paid	9b([*]	1)		59628		
		(2) Increase (decrease) in claim reserves	9b(2	2)				
		(3) Incurred claims (add (1) and (2))				9b(3)	5962	
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual ba						
		(A) Commissions				2995		
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs	- 445				4	
		(D) Other expenses				9553	4	
		(E) Taxes	- 113			459		
		(F) Charges for risks or other contingencies				2246	_	
		(G) Other retention charges	·			0-(4)(1)	4505	
		(H) Total retention					1525	
		(2) Dividends or retroactive rate refunds. (These amounts were		ш				
	d	(,	•			· · · ·		
		(2) Claim reserves					 	
	_	(3) Other reserves				` '		
10	e N Nic	Dividends or retroactive rate refunds due. (Do not include amou	int entered in line	9C(2)).)	9e		
10	_	lonexperience-rated contracts: Total premiums or subscription charges paid to carrier				10a		
	a							
	b	If the carrier, service, or other organization incurred any specific retention of the contract or policy, other than reported in Part I, li						
	Spe	ecify nature of costs.	inc 2 above, repor	t anno	Jant			
		··· , ··· · · · · · · · · · · · · · · ·						
P	art I	IV Provision of Information						
11		id the insurance company fail to provide any information necessary	v to complete Seh	مطبياء	Δ2	Yes	X No	
				euule	₹ M !	103	<u>n</u> .10	
14	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

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OMB No. 1210-0110

2017

pursuant to ERISA section 103(a)(2).				Inspection					
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017									
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	ERVICES PA D	BA FAMILY MEDICAL CENTERS	B Three-digit plan number (PN)			۱) 🕨	501		
C Plan sponsor's name as shown on line 2a of Form 5500 PHYSICIANS GROUP SERVICES PA D Employer Identification Number (E 59-3591435)						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		DA							
/L\	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	contract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To		
59-2403696	95089	70953	234	1	10/01/2017	7	12/31/2017		
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	ıl commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in		
(a) Total a	amount of comr			(b) To	otal amount	of fees paid			
		19520							
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).					
	(a) Name a	nd address of the agent, broker,				were paid			
MFB FINANCIAL INC			LANTATION ISLAND E GUSTINE, FL 32080	OR S STE 2	10				
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid					
commissions pai		(c) Amount		(d) Purpose			(e) Organization code		
	19520						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		Fee	s and other commissio	ons paid					
commissions pai		(c) Amount	(d) Purpose				(e) Organization code		
Fan Damamuanlı Danlıyatla	A a 4 Nla 4 i a a	see the Instructions for Form F	F00			Calaa	Iula A (Farm FEOO) 2017		

Schedule A (Form 5500)	2017	Page 2 – [1				
(a) No.			aminaiana ar fana wara naid				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid				
Fees and other commissions paid							
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose				Organization code			
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid				
(-)		,					
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization			
commissions paid	(c) Amount	(0	d) Purpose	code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
	Г			1			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization			
commissions paid	(c) Amount	((d) Purpose	code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
		Fees and other commissions p	naid	(e)			
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization			
commissions paid	(0)	,		code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
Fees and other commissions paid							
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	(e) Organization code			

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	idual contrac	ts 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 er			5	
		tracts With Allocated Funds:				
•	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	b	Premiums paid to carrier		[6b	
	C	Premiums due but unpaid at the end of the year		ŀ	6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ite participati	on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(*) 🗋 3***********************************				
	b	Palance at the and of the provious year		Ī	7b	
	C	Balance at the end of the previous year	7c(1)		70	
	C	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	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	
	е	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	

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P	art							
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ng purposes if such contr	acts are exp	érience-rated as a unit	. Where co	ontracts co	
8	Ben	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	сГ	Vision		d ☐ Life	insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	<u></u>	olovmont	브	scription drug
			<u>=</u>	·	<u>-</u>	лоуппепі		
	ן ו	Stop loss (large deductible)	j X HMO contract	k_	PPO contract		I Inde	emnity contract
	m	Other (specify)						
9	Exp	perience-rated contracts:	Г					
	а	Premiums: (1) Amount received		9a(1)		488002	2	
		(2) Increase (decrease) in amount due but unpaid	The state of the s	9a(2)				
		(3) Increase (decrease) in unearned premium rese	_	9a(3)				
		(4) Earned ((1) + (2) - (3))	T T			9a(4)		488002
	b	3 () 1		9b(1)		392256	5	
		(2) Increase (decrease) in claim reserves		9b(2)		01 (0)		000050
		(3) Incurred claims (add (1) and (2))				9b(3)		392256
	_	(4) Claims charged(1) Particular forms (4)				9b(4)		
	С	Remainder of premium: (1) Retention charges (or		0-(4)(A)		40500	_	
		(A) Commissions	T T	9c(1)(A) 9c(1)(B)		19520)	
		(B) Administrative service or other fees	ļ ·	9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(D)		C4F0(_	
		(D) Other expenses(E) Taxes	•	9c(1)(E)		61586		
		(F) Charges for risks or other contingencies	<u> </u>			0 14640		
		(G) Other retention charges				14040		
		(H) Total retention	-	•		9c(1)(H)	١	95746
		(2) Dividends or retroactive rate refunds. (These	_					
	d		—			9d(1)		
	u	(2) Claim reserves	•			9d(1)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no						
10		onexperience-rated contracts:	t morado amount ontoroa		.,			
	а	Total premiums or subscription charges paid to ca	arrier			10a		
	b	If the carrier, service, or other organization incurre						
	D	retention of the contract or policy, other than repo			•	10b		
	Spe	ecify nature of costs.	•	, I			•	
P	art	IV Provision of Information					_	
11	Die	id the insurance company fail to provide any informa	ation necessary to comple	ete Schedule	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

2017

		pursuant to Er	RISA section $103(a)(2)$.				Inspection	
For calendar plan year 20	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/3	31/2017		
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	BA FAMILY MEDICAL CENTERS		B Three-digit plan number (PN) 501			501		
C Plan sponsor's name as shown on line 2a of Form 5500 PHYSICIANS GROUP SERVICES PA D Employer Identification Number (E 59-3591435)							(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		COMPANY	,					
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate nui			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
57-0514130	71730	0000019906	271		01/01/201	7	12/31/2017	
2 Insurance fee and compared descending order of the		tion. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	amount of comr	nissions paid		(b) To	tal amount	of fees paid		
		21933						
3 Persons receiving com		es. (Complete as many entries a						
DETER HAGER	(a) Name a	nd address of the agent, broker, o	•	n commiss	ions or fees	were paid		
PETER HAGER			OTTINGHAM RD DNVLLE, FL 32210					
(b) Amount of sales ar	nd base	Fees	and other commission	s paid			_	
commissions pai		(c) Amount	(0	(d) Purpose			(e) Organization code	
	2704						3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commiss	ions or fees	were paid		
GREGORY M CRUICE 7121 TARPON CT FLEMING ISLAND, FL 32003								
(b) Amount of sales and base			Fees and other commissions paid					
commissions pai		(c) Amount	(((d) Purpose			(e) Organization code	
	1293						3	
E B	n Ant Nation	oo the Instructions for Form Fi	-00			Cala	dula A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page 2 – 1	
(a) Nar	ne and address of the agent broker	r, or other person to whom commissions or fees were paid	
HARDEN & ASSOCIATES	501 R SUITE	RIVERSIDE AVE E 1000 SONVILLE, FL 32202	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
4455			3
	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	<u>'</u>
CHARLES V GLAUB			
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
100			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
ASHLEY L CROOK			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
219			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	·
JAMEY J MILLER	4811 #107	BEACH BLVD SONVILLE, FL 32207	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
795			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
JASON I BODDIE	2900	RAVINE HILL DR ILEBURG, FL 32068	
(I) Assessed ()		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

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

2401 W BIG BEAVER RD

Fees and other commissions paid

(d) Purpose

(e)

Organization

code

STE 400 TROY, MI 48084

(c) Amount

HYLANT GROUP INC

(b) Amount of sales and base

commissions paid

616

Page	2 –	3	
Page	2 –	3	

	a) Nome and address	of the eacht broker	ar athar nara	tob		face	,ara naid
- (a) Name and address	or the agent, broker	, or other perso	on to whom	COMMISSIONS OF	rees v	vere paid

MARK A LINSNER

	F	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1415			3

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

BOR HOUSE ACCOUNT

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
12			3	

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

HEIDI E GLAUB

5458 PARKSIDE DR BRIGHTON, MI 48114

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
54			3	

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

MARK LINSNER

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
385			3	

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

MFB FINANCIAL INC

1200 PLANTATION ISLAND DR S STE 210 ST. AUGUSTINE, FL 32080

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
561			3

Schedule A (Form 5500) 20	17	Page 2 – 4	
(a) Name CECIL T SALMON	and address of the agent, broke	r, or other person to whom commissions or fees were paid	
CECIL I SALIVION			
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
97			3
(a) Name	and address of the agent, broke	r, or other person to whom commissions or fees were paid	
VERA I CRUICE		TARPON CT //ING ISLAND, FL 32003	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
7010			3
		r, or other person to whom commissions or fees were paid	
JAMES R MIRABELLI	STE 4	DIX ELLIS TRAIL 409 (SONVILLE, FL 32256	
(h) Amount of calco and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
495			3
(a) Name	and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Name	and address of the agent, broke	r, or other person to whom commissions or fees were paid	<u>'</u>

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

ı	Page	4

Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for repo employees, the entire group of such indivi	rting purposes if such cont	racts are exp	perience-rated as a uni	t. Where co	ontracts cover individual
R	Bor	efit and contract type (check all applicable boxes				u.p0000 0. t	
Ü	a	Health (other than dental or vision)	b Dental	сГ	Vision		d Life insurance
		<u>-</u>	<u> </u>	<u>_</u>			
	е	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify) SUPPLEMENTAL HEALTH	l				
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpa	id	9a(2)			
		(3) Increase (decrease) in unearned premium re	serve	9a(3)		1	
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves				1	
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (0 (4)(4)	1		_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			_
		(C) Other specific acquisition costs		0 (4)(D)			_
		(D) Other expenses		0 (4)(5)			_
		(E) Taxes(F) Charges for risks or other contingencies					_
		(G) Other retention charges					_
		(H) Total retention			<u> </u>	9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (Thes					
	d	Status of policyholder reserves at end of year: (_	_		• •	
	u	(2) Claim reserves	•			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do					
10	No	nexperience-rated contracts:			, ,	1	
	а	Total premiums or subscription charges paid to	carrier			. 10a	98536
	b	If the carrier, service, or other organization incu	rred any specific costs in c	onnection wi	ith the acquisition or		
		retention of the contract or policy, other than rep	• •		•	. 10b	
	Spe	cify nature of costs.					
_	0=1	W Provision of Information					
	art						
11		the insurance company fail to provide any infor		ete Schedule	e A?	Yes	X No
12	l If t	he answer to line 11 is "Yes," specify the informa	tion not provided.				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017		and er	nding 12/31/2017		
A Name of plan		BA FAMILY MEDICAL CENTER	RS WELFARE		Three-digit plan number (PN) 501		
C Plan sponsor's name as shown on line 2a of Form 5500 PHYSICIANS GROUP SERVICES PA D Employer Identification Numb 59-3591435					•	(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 UNION SECURITY INSUR		NY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a		Policy or o	ontract year	
(b) LIN	code	identification number	policy or contrac		(f) From	(g) To	
81-0170040	70408	5478474	178	3	01/01/2017	12/31/2017	
2 Insurance fee and come descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents, brokers, and o	other persons in	
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fees paid		
		14683			•		
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	sions or fees were paid		
HARDEN & ASSOCIATES			VERSIDE AVE STE 100 SONVILLE, FL 32202	00			
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code	
	10943					3	
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	sions or fees were paid		
MFB FINANCIAL	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL 1200 PLANTATION ISLAND DR S STE 210 ST. AUGUSINE, FL 32080						
(h) Amount of colors	nd book	Fee	es and other commission	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code	
·	3740					3	
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	5500		Scho	dule A (Form 5500) 2017	
. J. I abel WUIK NEUUCIIU		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		JUILE	uuio A (1 01111 JJUU) 401/	

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

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Р	art	III Welfare Benefit Contract Inform	ation				
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individuals.	ting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	intracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-	·	-	· · ·
	a	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	<u>L</u>	Supplemental unen	anloymont	h Prescription drug
				- 5		ipioyment	
	ן י	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9	Exp	erience-rated contracts:			T		_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_
		(3) Increase (decrease) in unearned premium res	•			0=/4)	
	h	(4) Earned ((1) + (2) - (3))	i			9a(4)	
	b	Benefit charges (1) Claims paid		(-)			-
		(2) Increase (decrease) in claim reserves	· ·			9b(3)	
		(4) Claims charged				9b(3)	
	С	Remainder of premium: (1) Retention charges (c		•••••		35(4)	
	Ü	(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		0.741701			
		(E) Taxes		0./4\/=\			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges					
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits afte	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			<u>10a</u>	147187
	b	If the carrier, service, or other organization incur			•		
	Sn.	retention of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report am	ount	<u> </u>	
	Spe	cify nature of costs.					
Р	art	IV Provision of Information					
11		the insurance company fail to provide any inform	nation necessary to compl	ata Schoduli	ο Δ2	Yes	X No
				ere ochedul	σ Λ!	1 .00	
14	. II T	he answer to line 11 is "Yes," specify the informat	ion not provided. 🔻				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to E	RISA section 103(a)(2).	-			Inspection	
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/3	31/2017		
A Name of plan PHYSICIANS GROUP SE BENEFITS PLAN	ERVICES PA D	BA FAMILY MEDICAL CENTERS	S WELFARE		B Three-digit plan number (PN) 501			
C Plan sponsor's name as shown on line 2a of Form 5500 PHYSICIANS GROUP SERVICES PA D Employer Identification Number (EIN) 59-3591435						(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 UNION SECURITY INSUR		ANY						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
81-0170040	70408	5478474	108		01/01/201	7	12/31/2017	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	amount of comi	missions paid 2727		(b) To	otal amount	of fees paid		
3 Persons receiving com		ees. (Complete as many entries a			iono or food	. wore poid		
HARDEN & ASSOCIATES			VERSIDE AVE STE 100 ONVILLE, FL 32202		ions or rees	s were palu		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	204682						3	
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL INC 1200 PLANTATION ISLAND DR S STE 210 ST. AUGUSTINE, FL 32080								
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid				
commissions pai		(c) Amount	(d) Purpose		e		(e) Organization code	
	67969						3	
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	500			Scher	dule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	а	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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion 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)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	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)			7 f	

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group of employees of the ing purposes if such contr	acts are ex	perience-rated as a u	nit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	v a	Supplemental une	mplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j X HMO contract	, S k		, ,	I Indemnity contract
	m	Other (specify)	, <u></u>	1			
	••••	_ Cities (specify) /					
9	Fxn	erience-rated contracts:					
Ŭ		Premiums: (1) Amount received		9a(1)			_
	ŭ	(2) Increase (decrease) in amount due but unpaid	F	9a(2)			_
		(3) Increase (decrease) in unearned premium res	To the second se	9a(3)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	
	b	Benefit charges (1) Claims paid	T T	9b(1)			
		(2) Increase (decrease) in claim reserves	<u> </u>	9b(2)			_
		(3) Incurred claims (add (1) and (2))	_			9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or					
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees	F	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)	1
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	penefits afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2) .)	9e	
10) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			<u>10a</u>	2723
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than repo				10b	
	Spe	cify nature of costs.					
Р	art	V Provision of Information					
11	Di	d the insurance company fail to provide any inform	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	on not provided.				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017		and en	nding 12/31/2017			
A Name of plan		BA FAMILY MEDICAL CENTER	S WELFARE		Three-digit plan number (PN) 501			
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Nur					•	(EIN)		
PHYSICIANS GROUP SERVICES PA 59-3591435								
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 cal UNION SECURITY INSUR		NY						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		Policy or c	ontract year		
(b) LIN	code	identification number	policy or contract		(f) From	(g) To		
81-0170040	70408	5478474	257	•	01/01/2017	12/31/2017		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tot	al commissions paid. Li	ist in line 3	the agents, brokers, and o	other persons in		
	amount of comr	missions paid		(b) To	otal amount of fees paid			
		2889			·			
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	sions or fees were paid			
HARDEN & ASSOCIATES			VERSIDE AVE STE 100	00				
		JACKS	SONVILLE, FL 32202					
(b) Amount of sales ar	nd hase	Fee	es and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code		
	2159					3		
	(a) Name a	nd address of the agent, broker,	•					
MFB FINANCIAL			LANTATION ISLAND D IGUSTINE, FL 32080	R S STE 2	:10			
(In) A server of the In-		Fee	es and other commission	ns paid				
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code		
	730					3		
For Paperwork Reductio	n Act Notice, s	see the Instructions for Form 5	5500.		Sche	dule A (Form 5500) 2017		

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	ts 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 en	5			
		tracts With Allocated Funds:				
•	а	State the basis of premium rates				
	_	otato ano suoto di promisimi attori				
	b	Premiums naid to carrier		[6b	
	C	•				
	d	Premiums due but unpaid at the end of the year				
	u	retention of the contract or policy, enter amount		6d		
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participati	on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(*) 🗋 3***********************************				
	b	Palance at the end of the provious year		i	7b	
	C	Balance at the end of the previous year	7c(1)		7.0	
	•	(2) Dividends and credits	7c(1)			
		• •	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	_
	е	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			Ī	7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

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Р	art							
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same than the contract covers the same that the contract covers the same that the covers the contract covers the same that the covers the covers the same that the covers the covers the same that the covers	ting purposes if such cont	racts are exp	perience-rated as a ur	nit. Where co	ntracts cover individual	
8	Ben	efit and contract type (check all applicable boxes)		-		-	· · ·	
	а	Health (other than dental or vision)	b Dental	c	X Vision		d Life insurance	
	L		<u> </u>	<u> </u>	=	nnlaumant		
	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental uner	прюуттепт	h Prescription drug	
	İ	Stop loss (large deductible)	j HMO contract	k [PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Exp	erience-rated contracts:			1			
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpai	d	9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))	i		 T	9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)			_	
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))						
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	· · · · · · · · · · · · · · · · · · ·		1		_	
		(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) Charge for right an other continuous					-	
		(F) Charges for risks or other contingencies. (G) Other retention charges					-	
			•			9c(1)(H)		
		(H) Total retention						
	لہ	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash,						
	d	Status of policyholder reserves at end of year: (1	•			` `		
		(2) Claim reserves				9d(2)	+	
	е	(3) Other reserves Dividends or retroactive rate refunds due. (Do n				` `		
10	_	nexperience-rated contracts:	of include amount entered	1 111 1111E 3C(2	<i>]</i> .)	36		
10	a	Total premiums or subscription charges paid to	carrier			10a	28827	
	-					104	2002	
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b		
	Spe	cify nature of costs.	ortod iii i dit i, iiilo 2 dbov	o, roport am	Odi (
		·						
Part IV Provision of Information								
11			nation necessary to compl	ete Schedul	е А?	Yes	X No	
	The state measures company take provide any monator measures company to the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide any monator management and the provide and the provide any monator management and the provide any monator management and the provide and the							
14	12 If the answer to line 11 is "Yes," specify the information not provided.							