Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

Part I	Annual Report I	dentification Information						
For cale	ndar plan year 2016 or fis	cal plan year beginning 12/01/2016		and ending 11/30/2017	7			
A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)						ns.)		
		x a single-employer plan	a DFE (specit	fy)				
B This	return/report is:	the first return/report	the final return	•				
	an amended return/report a short plan year return/report (less than 12 months)							
C If the	plan is a collectively-barg	gained plan, check here				• 🗌		
D Chec	k box if filing under:	Form 5558	automatic exte	ension	the	e DFVC program		
	1	special extension (enter descriptio	,					
Part II		mation—enter all requested informat	tion				1	
	ne of plan FPEST CONTROL, INC V	VELFARE BENEFIT PLAN			1b	Three-digit plan number (PN) ▶	501	
					1c	Effective date of plants 12/01/2013	an	
Mail	ing address (include roon	ver, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box e, country, and ZIP or foreign postal coo		ructions)	2b	Employer Identifica Number (EIN) 59-2992941	ation	
	PEST CONTROL, INC.				2c	Plan Sponsor's tele	ephone	
DEANS	SERVICES					number 352-787-5300		
PO BOX FRUITLA	519 ND PARK, FL 34731-051	PO BOX FRUITLA	519 .ND PARK, FL 34731	-0519	2d Business code (see instructions) 561710			
Caution	: A penalty for the late o	or incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is e	stablis	shed.		
Under po	enalties of perjury and oth	ner penalties set forth in the instructions yell as the electronic version of this retu	, I declare that I have	e examined this return/report, inc	cluding	accompanying sche		
SIGN	Filed with authorized/vali	d electronic signature	07/17/2018	BRANDI GIL				
HERE	Signature of plan adm		Date	Enter name of individual sign	signing on plan administrator			
	Signature of plan aum	mistrator	Date	Litter frame of individual sign	iii iy as	piari administrator		
SIGN	Filed with authorized/vali	d electronic signature.	07/17/2018	BRANDI GIL				
HERE	Signature of employer	/plan sponsor	Date	Enter name of individual sign	ning as	employer or plan sp	onsor	
SIGN HERE								
Signature of DFE Date Enter name of individual signing					ning as	DFE		
Preparer's name (including firm name, if applicable) and address (include room or suite number)				arer's f	telephone number			

Form 5500 (2016) Page **2**

3a	Plan administrator's name and address X Same as Plan Sponsor	3b Administrator's EIN		
			l l	ninistrator's telephone nber
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed for this plan, enter the name,	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year		5	175
6	Number of participants as of the end of the plan year unless otherwise states 6a(2), 6b, 6c, and 6d).	d (welfare plans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		6a(1)	175
a(2	Total number of active participants at the end of the plan year		6a(2)	173
b	Retired or separated participants receiving benefits		6b	
С	Other retired or separated participants entitled to future benefits		6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	173	
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	6e	
f	Total. Add lines 6d and 6e.		6f	173
g	Number of participants with account balances as of the end of the plan year complete this item)		6g	
	Number of participants that 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		7	
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan	des from the List of Plan Characteristics Codes	s in the in	
уа	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all that (1) Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance	e contracts
	(3) Trust (4) X General assets of the sponsor	(3) Trust (4) X General assets of the specific control	oonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a			ned. (See instructions)
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) I (Financial Inform (3) X 3 A (Insurance Inform (4) C (Service Provide	mation)	,
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participation of the details of the deta	-	

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
11a If the 2520	plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 1.101-2.)
lf "Y€	es" is checked, complete lines 11b and 11c.
11b Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
Rece	r the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the eipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid eipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)
Rece	eipt Confirmation Code

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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.

OMB No. 1210-0110

2016

T GISION DENGIN OC	aranty corporation		ERISA section 103(a)(2)	Inspection			
For calendar plan	year 2016 or fiscal	plan year beginning 12/01/2016		and en	iding 11/30	/2017	
A Name of plan DEANS PEST CO	NTROL, INC WELF	FARE BENEFIT PLAN			e-digit number (PN) •	501
C Plan sponsor's DEANS PEST CO		line 2a of Form 5500			oyer Identifica 2992941	ation Number	(EIN)
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Inform (a) Name of insura UNITEDHEALTHC	ance carrier	COMPANY					
(b) EIN	(c) NAI code	C (d) Contract or identification number	(e) Approximate not persons covered a policy or contract	t end of	(f)	Policy or o	contract year (g) To
36-2739571	79413	555630		182 12/0			12/31/2016
	nd commission info er of the amount pa	rmation. Enter the total fees and to id.	otal commissions paid. Li	ist in line 3	the agents, b	orokers, and	other persons in
(a	Total amount of c	ommissions paid		(b) To	otal amount o	of fees paid	
352 0					0		
3 Persons receivi	ng commissions ar	nd fees. (Complete as many entries	s as needed to report all	persons).			
HYLANT GROUP II	• • • • • • • • • • • • • • • • • • • •	ne and address of the agent, broker 250 IN	r, or other person to who ITERNATIONAL PARKW			were paid	
		LAKE	MARY, FL 32746				
(b) Amount of	sales and hase	Fe	es and other commission	ns paid			
commiss		(c) Amount		(d) Purpose		(e) Organization code	
352		0					3
	(a) Nam	ne and address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
		•				·	
(b) Amount of sales and base Fees and other commissions paid			-				
commiss		(c) Amount		(d) Purpose			(e) Organization code
	1 41 4 11 41	4 1 4 6 6 5	EE00				/= =====

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

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

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

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Pa	rt III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract of	group of employees of th ting purposes if such con	tracts are expe	erience-rated as a unit	t. Where co	ontracts cover	
8 E	Benefi	t and contract type (check all applicable boxes)						
á	a X	Health (other than dental or vision)	b Dental	С	Vision		d Life insu	ırance
•	• 🗍	Temporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unem	ployment	h Prescrip	otion drug
i		Stop loss (large deductible)	j HMO contract	· <u> </u>	PPO contract		- =	ity contract
r		Other (specify)	, e seac.		1		- L	.,
9 E	xperie	ence-rated contracts:						
a	a Pre	emiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid		9a(2)				
	(3) Increase (decrease) in unearned premium res	serve	9a(3)				
	(4) Earned ((1) + (2) - (3))		· <u>·····</u>		. 9a(4)		
	b B	enefit charges (1) Claims paid		9b(1)				
	(2) Increase (decrease) in claim reserves		9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		
	(4) Claims charged				9b(4)		
	C R	emainder of premium: (1) Retention charges (n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)			_	
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes		9c(1)(E)			_	
		(F) Charges for risks or other contingencies		0 - (4)(0)			_	
		(G) Other retention charges				0. (4) (11)		
		(H) Total retention	_	_		9c(1)(H))	
		2) Dividends or retroactive rate refunds. (These				9c(2)		
		tatus of policyholder reserves at end of year: (1	•			9d(1)		
	,	2) Claim reserves				9d(2)		
	,	3) Other reserves				9d(3)	_	
		ividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2) .	.)	9e		
10		xperience-rated contracts:						
	a ⊺	otal premiums or subscription charges paid to o	carrier			10a		58262
		the carrier, service, or other organization incur				406		
		etention of the contract or policy, other than rep y nature of costs.	orted in Part I, line 2 abov	ve, report amo	ount	10b		
Pa	rt IV	Provision of Information						
11	Did th	ne insurance company fail to provide any inforn	nation necessary to comp	lete Schedule	A?	Yes	X No	
		answer to line 11 is "Yes," specify the informat			<u> </u>			

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 201	16 or fiscal plan	year beginning 12/01/2016		and en	ding 11/30/2017	•	
A Name of plan DEANS PEST CONTROL	, INC WELFAR	E BENEFIT PLAN			B Three-digit plan number (PN) 501		
					,	,	
•	C Plan sponsor's name as shown on line 2a of Form 5500 DEANS PEST CONTROL, INC.				oyer Identification Number	(EIN)	
DEANOTEOT CONTROL,	, iivo.			00 2	2002041		
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:							
(a) Name of insurance car UNITEDHEALTHCARE INS		MPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			ontract year	
(b) LIN	code	identification number	policy or contrac		(f) From	(g) To	
36-2739571	79413	555630	173		01/01/2017	12/31/2017	
2 Insurance fee and comr descending order of the		tion. Enter the total fees and tot	tal commissions paid. Li	ist in line 3	the agents, brokers, and o	ther persons in	
(a) Total a	amount of comn			(b) To	otal amount of fees paid		
		38906				1988	
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	(a) Name ar	nd address of the agent, broker,					
HYLANT GROUP, INC.			TERNATIONAL PARKW MARY, FL 32746	/AY SUITE	330		
(b) Amount of sales an	nd base	Fee	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose		e	(e) Organization code	
	38906	1988 ^B (ONUS			3	
	(a) Name ar	nd address of the agent, broker,	, or other person to whor	m commiss	ions or fees were paid		
(b) Amount of sales and base		Fee	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	e	(e) Organization code	
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule A (Form 5500) 2016 v. 160205							

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

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

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

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P	art II								
		the information may be o	combined for repor	group of employees of the ting purposes if such con lual contracts with each c	tracts are expe	erience-rated as a uni	t. Where cont	racts cov	
8	Bene	fit and contract type (check al	applicable boxes)						
	a X	Health (other than dental or	vision)	b Dental	С	Vision	d	Life i	insurance
	е	Temporary disability (accide	nt and sickness)	f Long-term disabil	itv a	Supplemental unem	ployment h	☐ Pres	cription drug
	. H	Stop loss (large deductible)	,	j HMO contract		PPO contract	,	브	mnity contract
	m	Other (specify)		,	••_	1110001111401	•	Шао.	mility continuot
	m _	Other (specify)							
9	Evnor	rience-rated contracts:							
3	•	remiums: (1) Amount received	4		9a(1)				
		2) Increase (decrease) in amo							
	•	3) Increase (decrease) in une	•						
	•	(4) Earned ((1) + (2) - (3))	•				9a(4)		
	_ `	Benefit charges (1) Claims pa					, ,		
		2) Increase (decrease) in clai			(-)				
	(3) Incurred claims (add (1) an	d (2))				9b(3)		
	(4) Claims charged					9b(4)		
	C	Remainder of premium: (1) Re	etention charges (d	on an accrual basis)					
		(A) Commissions			9c(1)(A)				
		(B) Administrative service	or other fees						
		(C) Other specific acquisit							
		(D) Other expenses			0-(4)(5)				
		(E) Taxes							
		(F) Charges for risks or ot	=		0 (4)(0)				
		(G) Other retention charge (H) Total retention					9c(1)(H)		
		(2) Dividends or retroactive ra		_					
							9c(2)		
		Status of policyholder reserve (2) Claim reserves	• •				9d(1) 9d(2)		
		(3) Other reserves					9d(3)		
		Dividends or retroactive rate r					9e		
10		experience-rated contracts:	0.000 0.00. (20	<u> </u>	<u> </u>	·/·····	1 00		
		Total premiums or subscriptio	n charges paid to	carrier			10a		582231
	b	If the carrier, service, or other	organization incur	red any specific costs in	connection with	h the acquisition or			
		retention of the contract or po					10b		
	Spec	ify nature of costs.							
P	art I\	/ Provision of Infor	mation						
		the insurance company fail to		nation necessary to comm	olete Schedulo	Δ? Π	Yes	No	
					nete Scriedule	Λ:	100	140	
12	If th	e answer to line 11 is "Yes," s	pecity 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.

OMB No. 1210-0110

2016

,	,		RISA section 103(a)(2).	iormation	This F	orm is Open to Public Inspection
For calendar plan year 20	16 or fiscal plar	n year beginning 12/01/2016		and endin	ng 11/30/2017	
A Name of plan DEANS PEST CONTROL	, INC WELFAR	RE BENEFIT PLAN	В	Three-d plan nu	ligit ımber (PN)	501
C Plan sponsor's name a DEANS PEST CONTROL	er (EIN)					
		rning Insurance Contract Lindividual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca		AMERICA				
	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or	contract year
(b) EIN	code	identification number	persons covered at end policy or contract year		(f) From	(g) To
01-0278678	62235	423129	113	01	1/01/2017	12/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	Il commissions paid. List in	line 3 the	e agents, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		816				247
3 Persons receiving com		ees. (Complete as many entries				
HYLANT GROUP, INC.	(a) Name a	and address of the agent, broker,	or other person to whom co DISON AVENUE	mmission	is or fees were paid	
			D, OH 43604			
(b) Amount of sales ar	nd base	Fee	s and other commissions pa	aid		
commissions pa	id	(c) Amount	(d) F	(d) Purpose		(e) Organization code
	816	247				3
	(a) Name a	and address of the agent, broker,	or other person to whom co	mmission	s or fees were paid	
(b) Amount of sales ar	nd base	Fees and other commi		aid		
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
For Paperwork Reductio	n Act Notice,	see the Instructions for Form 5	500.		Sch	edule A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page 2 – 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(a) Nai	ne and address of the agent, bio	iker, or other person to whom commissions or lees were paid				
		(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid				

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

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

P	art	If more than one contract covers the same the information may be combined for report	group of employees of the ing purposes if such cont	racts are expe	érience-rated as a unit. W	here cor	ntracts cover individual
		employees, the entire group of such individ		arrier may be t	treated as a unit for purpo	ses of th	is report.
8	Ben	efit and contract type (check all applicable boxes)	_				- 🗔
	а	Health (other than dental or vision)	b Dental	c 🗌	Vision		d X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemploy	ment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k□	PPO contract		I X Indemnity contract
	m	Other (specify)	_	_			_
	L						
9	Ехре	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)				
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		L	1 _		
		(H) Total retention				c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or 🔲 c	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	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 c	arrier			10a	6164
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than reposits potents of poets.				10b	
		cify nature of costs.					
	art					-	=
11	Dio	the insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A? Ye	s i	X No
12	If t	he answer to line 11 is "Yes," specify the informati	on not provided.				