Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Administration		the instructions to the Form 5500.						
Pensio	on Benefit Guaranty Corporation				This Form is Open to Public Inspection			
Part I		dentification Information						
For cale	ndar plan year 2017 or fis	cal plan year beginning 01/01/2017	_	and ending 12/31/20	017			
A This	return/report is for:	a multiemployer plan		ployer plan (Filers checking t employer information in accor	this box must attach a list of rdance with the form instructions.)			
		x a single-employer plan	a DFE (specif	y)				
B This	eturn/report is:	the first return/report	the final return	the final return/report				
		X an amended return/report	a short plan ye	ear return/report (less than 1	2 months)			
C If the	plan is a collectively-barg	gained plan, check here						
D Chec	k box if filing under:	X Form 5558	automatic exte	nsion	the DFVC program			
	•	special extension (enter description	n)		_			
Part II	Basic Plan Infor	mation—enter all requested informati	on					
1a Nam	ne of plan INC. WELFARE BENEF	·	-		1b Three-digit plan number (PN) ▶ 502			
					1c Effective date of plan 01/01/2010			
Mail City	sponsor's name (employ ing address (include room or town, state or province	2b Employer Identification Number (EIN) 90-0579240						
REVEL, I	NC. CONSULTING				2c Plan Sponsor's telephone number 206-407-3173			
	D AVE, SUITE 300 E, WA 98106	2226 3RD AVE, SUITE 300 SEATTLE, WA 98106			2d Business code (see instructions) 541910			
Caution	: A penalty for the late o	or incomplete filing of this return/repo	rt will be assessed	unless reasonable cause i	is established.			
		er penalties set forth in the instructions, vell as the electronic version of this retur						
SIGN	Filed with authorized/vali	d electronic signature.	09/14/2018	TANA SINNOTT				
HERE	Signature of plan adm	inistrator	Date Enter name of individual signing as plan					
					. 0 0			
SIGN HERE								
HERE	Signature of employer	/plan sponsor	Date	Enter name of individual s	signing as employer or plan sponsor			
SIGN								

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

HERE

Signature of DFE

Form 5500 (2017) v. 170203

Enter name of individual signing as DFE

	Form 5500 (2017)	Pag	ge 2		
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Administra	tor's EIN
				3c Administra	tor's telephone
				number	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin	nce the last retu	urn/report filed for this plan,	4b EIN	
•	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name			4d PN	
C	Plan Name			4u PN	
5	Total number of participants at the beginning of the plan year			5	201
6	Number of participants as of the end of the plan year unless otherwise stated	d (welfare plans	complete only lines 6a(1),	3	201
	6a(2), 6b, 6c, and 6d).		, , , , , , , , , , , , , , , , , , , ,		
a(1) Total number of active participants at the beginning of the plan year			. 6a(1)	191
a(2) Total number of active participants at the end of the plan year			6a(2)	152
b	Retired or separated participants receiving benefits			6b	3
С	Other retired or separated participants entitled to future benefits			6с	
d	Subtotal. Add lines 6a(2), 6b, and 6c			. 6d	155
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits		6e	
f	Total. Add lines 6d and 6e .			6f	
•					
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	h accrued hene	fits that were		
	less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only	. , ,	. ,	7	
ŏа	If the plan provides pension benefits, enter the applicable pension feature co	des from the Lis	st of Plan Characteristics Cod	es in the instructi	ons:
h	If the plan provides welfers havefite appear the applicable welfers feeture and	laa fram tha Lia	t of Dian Characteristics Code	a in the inetwestic	
D	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E 4F 4H 4Q	es from the List	t of Plan Characteristics Code	s in the instruction	IIIS.
0-					
9a	Plan funding arrangement (check all that apply) (1)	9D Plan ben	nefit arrangement (check all th	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance contra	acts
	(3) Trust (4) General assets of the sponsor	(3) (4)	Trust General assets of the s	noncor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a				ee instructions)
а	Pension Schedules		I Schedules	,	,
4	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform	nation – Small Pl	an)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X 10 A (Insurance Info	rmation)	
	actuary	(4)	C (Service Provid	,	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participat	-	
	Information) - signed by the plan actuary	(6)	G (Financial Trans	saction Schedule	es)

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.)			
Recei	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 pt 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 pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)			
Rece	ipt Confirmation Code			

Form 5500 (2017)

Page 3

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 plan	year beginning 01/01/2017	and	ending 12/31/2017	оросион		
A Name of plan	o. noca. p.a.	. year 20gg 01/01/2017	_	B Three-digit			
REVEL, INC. WELFARE BENEFITS PLAN				an number (PN)	502		
			<u> </u>	arriamor (114)			
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		ployer Identification Numb	er (EIN)		
REVEL, INC.			9	90-0579240			
David Informat	ion Consor	ning Inquironae Contrae	t Covered Face and C	ammicolono Daniela	Consection to a section of		
			t Coverage, Fees, and Co as a unit in Parts II and III can be				
1 Coverage Information:		<u> </u>		1 3			
(a) Name of insurance ca							
DELTA DENTAL OF WASI	HINGTON						
			(e) Approximate number of	Policy o	r contract year		
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of	(f) From	(g) To		
	0000	identification number	policy or contract year	(1) 110111	(9) 10		
91-0621480	47341	07530	272	01/01/2017	12/31/2017		
2 Inquironae foe and com	mission informs	tion. Enter the total fees and to	tal commissions paid. List in line	2 the agente brokers and	d other persons in		
descending order of the		mon. Enter the total lees and to	iai commissions paid. List in line	s the agents, brokers, and	u otner persons in		
(a) Total a	amount of comr	nissions paid	(b)	Total amount of fees paid			
		7346			0		
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all persons).			
			, or other person to whom comm				
GALLAGHER BENEFIT SE		777 - 1	108TH AVE NE STE 200				
		BELLE	EVUE, WA 98004				
(b) Amount of sales ar			es and other commissions paid	(-) (0			
commissions pai	6159	(c) Amount	(d) Purp	ose	(e) Organization code		
	0159				3		
	/ \ \ \ \			,			
TRUEDENIEUTO LLO	(a) Name a		, or other person to whom comm	issions or fees were paid			
TRUEBENEFITS LLC 1215 4TH AVE STE 2200 SEATTLE, WA 98161							
(b) Amount of sales and base		<u>F</u> e	es and other commissions paid				
commissions pai		(c) Amount	(d) Purp	ose	(e) Organization code		
	1187				3		
For Panerwork Reduction	n Act Notice s	see the Instructions for Form	5500	Sc	hedule 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 (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)				
	_			. \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	

ı	Page	4

P	art	III Welfare Benefit Contract Information If more than one contract covers the same grouthe information may be combined for reporting	ip of employees of the				
		employees, the entire group of such individual					
8	Bene	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	X Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness) f	Long-term disability	√ g ¯	Supplemental un	employment	h Prescription drug
	ιŤ	Stop loss (large deductible)	HMO contract	, o∟ k∫	=	, ,	I Indemnity contract
	m			_			
	L	United (Specify)					
9	Expe	perience-rated contracts:					
		Premiums: (1) Amount received	Г	9a(1)		147776	_
		(2) Increase (decrease) in amount due but unpaid	-	9a(2)			_
		(3) Increase (decrease) in unearned premium reserve		9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	14777
				9b(1)		101475	
		(2) Increase (decrease) in claim reserves		9b(2)		2000	
		(3) Incurred claims (add (1) and (2))				9b(3)	10347
		(4) Claims charged				9b(4)	
	C	Remainder of premium: (1) Retention charges (on ar	accrual basis)			•	
		(A) Commissions		9c(1)(A)		7345	
		(B) Administrative service or other fees		9c(1)(B)		27234	
		(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	<u> </u>	9c(1)(F)			_
		(G) Other retention charges	_	9c(1)(G)		0.40410	2453
		(H) Total retention	_				3457
	_	(2) Dividends or retroactive rate refunds. (These am					
	d	Status of policyholder reserves at end of year: (1) An	·			· · ·	
		(2) Claim reserves					600
	_	(3) Other reserves					
4.0	<u>e</u>	Dividends or retroactive rate refunds due. (Do not in	clude amount entered	in line 9c(2)	<u>).)</u>	9e	
10	_	onexperience-rated contracts:				10a	
	a	Total premiums or subscription charges paid to carrie					
	b	If the carrier, service, or other organization incurred a retention of the contract or policy, other than reported					
	Spe	ecify nature of costs.	u III Fait I, IIIIe Z above	e, report ann	ount		
	-1	,					
Р	art I	IV Provision of Information					
11		id the insurance company fail to provide any informatio	n necessary to comple	ete Schedule	e A?	Yes	X No
		the answer to line 11 is "Yes," specify the information r		2.5 Conodan			<u> </u>
		and another to mile in to 100, opening the information i	.c. promaca.				

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

For calendar	pian year 201	i / or fiscai piar	n year beginning 01/01/2017		and en	iding 12/31/201	7	
A Name of p					B Thre	e-digit		
REVEL, INC. WELFARE BENEFITS PLAN				plan	number (PN)	•	502	
C DI		h P -	. 0 (5 5500		D. F		N. I II	(EIN)
•		s shown on line	e 2a of Form 5500			oyer Identification	Number	(EIN)
REVEL, INC					90-	0579240		
Part I	Informat	ion Concer	ning Insurance Contrac	et Coverage Foos	and Con	nmissions Dro	vido info	rmation for each contract
Parti			. Individual contracts grouped					
1 Coverage			3 - 1 - 1			,		
1 Coverage	iiiioiiiialioii.							
(a) Name of	insurance car	rrier						
UNUM LIFE I	NSURANCE (COMPANY OF	AMERICA					
		T						
(b)	FIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year
(5)		code	identification number	policy or contrac		(f) From	1	(g) To
01-0278678		62235	219067	152		01/01/2017		12/31/2017
		mission informa amount paid.	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, broke	rs, and c	other persons in
		mount of com	missions paid		(b) To	otal amount of fee	s paid	
	. ,		8205					634
2 Daragna r		missions and f	ana (Camplete as many entries		noroono)			
3 Persons r	eceiving comi		ees. (Complete as many entries			·		
GALLAGHER	DENIEUT OF		and address of the agent, broker	r, or otner person to wno 108TH AVE NE STE 200		ions or fees were	paid	
GALLAGHER	DENETH SE	RVICES		EVUE, WA 98004)			
(b) Amou	nt of sales an	d bass	Fe	ees and other commission	ns paid			
	nmissions pai		(c) Amount		e		(e) Organization code	
	•	6711			` ' '			3
		(a) Nama a	and address of the agent, broker	r or other person to who	m commiss	ions or foos wors	poid	
TRUEBENEF	ITCLLC	(a) Name a		4TH AVE STE 2200	III COITIIIISS	ions or rees were	paiu	
TROUBLINE	II 3 LLC			TLE, WA 98161				
(b) Amount of sales and base Fees and oth			es and other commission	ns paid				
	nmissions pai		(c) Amount		(d) Purpose			(e) Organization code
	•	1494		ADDITIONAL COMPENS	SATION			3
For Paperwo	ork Reduction	n Act Notice,	see the Instructions for Form	5500.			Sche	dule A (Form 5500) 2017 v. 170203
								0200

Schedule A (Form 5500) 201	17	Page 2 - 1	
(a) Name a	and address of the agent, broker,	, or other person to whom commissions or fees were paid	
GALLAGHER BENEFIT SERVICES INC	2850 V	W GOLF RD, 11TH FLOOR ING MEADOWS, IL 60008	
	ſ	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	559	ADDITIONAL COMPENSATION	3
(a) Name a	and address of the agent, broker,	, or other person to whom commissions or fees were paid	
	ŀ	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Name of	and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Nume o	and address of the agent, broker,	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Name a	and address of the agent, broker,	, or other person to whom commissions or fees were paid	
	F	Fees and other commissions paid	(e)
(b) Amount of sales and base	(a) Amount	(d) Durnage	Organization

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

Fees and other commissions paid

(d) Purpose

(d) Purpose

code

(e) Organization code

commissions paid

(b) Amount of sales and base commissions paid

(c) Amount

(c) Amount

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

F	Part	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	group of employees of the ing purposes if such contr	racts are ex	perience-rated as a	a unit. Where co	entracts 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 disabilit	v a	Supplemental u	nemployment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	, s k			I Indemnity contract	
	'		· 🗀	K			I I indemnity contract	
	m	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT					
0								_
9		erience-rated contracts: Premiums: (1) Amount received	[9a(1)				
	а	(2) Increase (decrease) in amount due but unpaid	•					
		(3) Increase (decrease) in unearned premium res		9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		_
	b	Benefit charges (1) Claims paid				············· • • • • • • • • • • • • •		П
		(2) Increase (decrease) in claim reserves	•					
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged						
	С	Remainder of premium: (1) Retention charges (o	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	•	9c(1)(G)		2 (1)(1)		
		(H) Total retention						_
		(2) Dividends or retroactive rate refunds. (These	_			` '		_
	d	Status of policyholder reserves at end of year: (1	•			` '		_
		(2) Claim reserves						
	_	(3) Other reserves				· · · · ·		_
11	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	2) .)	9e		_
10	_	nexperience-rated contracts:	parriar			10a	E71	
	a	Total premiums or subscription charges paid to c					571	<u> </u>
	b Spe	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo- cify nature of costs.						
F	art	V Provision of Information						_
11	l Di	the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	le A?	Yes	X No	
12	2 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

Fan aslandar de como com	17 au fia 1 - 2				alla acceptance	_			
_	For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017								
A Name of plan REVEL, INC. WELFARE I	BENEFITS PLA	AN			e-digit number (PN)	•	502		
C Plan sponsor's name as shown on line 2a of Form 5500 REVEL, INC. D Employer Identification Number (EIN) 90-0579240									
		ning Insurance Contrac Individual contracts grouped a							
1 Coverage Information:									
(a) Name of insurance car PREMERA BLUE CROSS	rrier								
	(c) NAIC	(d) Contract or	(e) Approximate num		Po	olicy or co	ntract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From		(g) To		
91-0499247	47570	1038501/4000324	271		01/01/2017		12/31/2017		
2 Insurance fee and commodescending order of the		ntion. Enter the total fees and to	tal commissions paid. List	t in line 3	the agents, broker	rs, and ot	her persons in		
(a) Total a	mount of comn	nissions paid		(b) To	otal amount of fees	s paid			
		52349					0		
3 Persons receiving com		ees. (Complete as many entries							
		nd address of the agent, broker		commiss	ions or fees were	paid			
GALLAGHER BENEFIT SE	ERVICES		108TH AVE NE STE 200 EVUE, WA 98004						
(b) Amount of sales an	nd base	<u>Fe</u>	es and other commissions	paid					
commissions pai		(c) Amount	(d	(d) Purpose			(e) Organization code		
	39579						3		
	(a) Name a	nd address of the agent, broker	r, or other person to whom	commiss	ions or fees were	paid			
TRUEBENEFITS LLC			4TH AVE STE 2200 TLE, WA 98161						
(b) Amount of sales and base Fees and other commissions paid									
(b) Amount of sales an commissions pai		(c) Amount		l) Purpose	е		(e) Organization code		
	12770						3		
For Panerwork Reduction	n Act Notice s	see the Instructions for Form	5500			Schen	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	((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	

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 cont	racts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-	·		i
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	L	Temporary disability (accident and sickness)	f Long-term disabilit	<u>L</u>	Supplemental unen	anlaymant	h X Prescription drug
	e			- 5		ipioyinent	
	ן י	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9		erience-rated contracts:			1		
	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			<u> </u>	9b(3)	
		(4) Claims charged				9b(3)	
	С	Remainder of premium: (1) Retention charges (o		•••••		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		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)	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	benefits afte	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	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>	1310375
	b	If the carrier, service, or other organization incurr			•		
	Sn.	retention of the contract or policy, other than repo	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		d the insurance company fail to provide any inform	nation necessary to compl	ete Schedule	е А?	Yes	X No
				ere ochedul	⊌ ∧!	1 .00	<u>~</u>
14	. II 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

		parsaant to E	1110A 30011011 103(a)(2).			Inspection		
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017	а	nd ending 12/3	1/2017			
A Name of plan REVEL, INC. WELFARE	BENEFITS PLA	AN	В	Three-digit plan number (PN	J) •	502		
C Plan sponsor's name a REVEL, INC.	as shown on line	e 2a of Form 5500	D i	Employer Identifica 90-0579240	ation Number	(EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca		AMERICA						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end		Policy or o	contract year		
(b) EII1	code	identification number	policy or contract year	(7)	From	(g) To		
01-0278678	62235	218807	33	01/01/2017	7	10/01/2017		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List in l	ine 3 the agents,	brokers, and	other persons in		
(a) Total	amount of comr	missions paid		(b) Total amount	of fees paid			
	2258 161							
3 Persons receiving com		ees. (Complete as many entries						
CALLACHED DENEELT CO		nd address of the agent, broker,		nmissions or fees	were paid			
GALLAGHER BENEFIT S	ERVICES INC		18TH AVE NE STE 200 VUE, WA 98004					
(b) Amount of sales a	nd base	Fee	es and other commissions pai	d				
commissions pa		(c) Amount	(d) Pt	urpose		(e) Organization code		
	2258					3		
	(a) Name a	nd address of the agent, broker.	or other person to whom con	nmissions or fees	were paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid GALLAGHER BENEFIT SERVICES INC 2850 W GOLF RD, 11TH FLOOR ROLLING MEADOW, IL 60008								
(b) Amount of sales a	nd hase	Fee	es and other commissions pai	d				
commissions pa		(c) Amount	(d) Pt	urpose		(e) Organization code		
	0	161 Al	DDITIONAL COMPENSATIO	N		3		

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(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	((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	

ı	Page	4

F	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 conti	acts are ex	perience-rated as a un	it. Where co	ntracts 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 disabilit	v a	Supplemental unem		h Prescription drug
	• [Stop loss (large deductible)	j HMO contract	, s k	=	ipioyinoni	I Indemnity contract
	' [I I IIVIO contract	N [FFO contract		
	m	Other (specify)					
_	_						
9		erience-rated contracts:	ſ	0-(4)		40004	_
	а	Premiums: (1) Amount received	ŀ	9a(1)		12901	_
		(2) Increase (decrease) in amount due but unpaid		9a(2)		0	
		(3) Increase (decrease) in unearned premium res		9a(3)		02(4)	1290
	b	(4) Earned ((1) + (2) - (3))	ſ	9b(1)		9a(4)	1230
	D	(2) Increase (decrease) in claim reserves	ľ	9b(1) 9b(2)			-
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o				05(4)	
	·	(A) Commissions	i	9c(1)(A)			-
		(B) Administrative service or other fees	ľ	9c(1)(B)			-
		(C) Other specific acquisition costs	ŀ	9c(1)(C)			-
		(D) Other expenses		9c(1)(D)			
		(E) Taxes	l	9c(1)(E)			1
		(F) Charges for risks or other contingencies	ŀ	9c(1)(F)			1
		(G) Other retention charges		9c(1)(G)			1
		(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					
		(2) Claim reserves	•			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	2) .)	9e	
10) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			. 10a	
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection w	ith the acquisition or		
		retention of the contract or policy, other than reportify nature of costs.	orted in Part I, line 2 above	e, report am	nount	10b	
P	art	IV Provision of Information			-	, ,	
11	Die	the insurance company fail to provide any inform	ation necessary to compl	ete Schedul	le A?	Yes	X No
12	2 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

		F ************************************				Inspection		
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017			
A Name of plan				B Thre	e-digit			
REVEL, INC. WELFARE BENEFITS PLAN				plan	number (PN)	502		
					,	_		
C Plan sponsor's name a	ıs shown on lin	e 2a of Form 5500		D Emplo	yer Identification Numbe	r (EIN)		
REVEL, INC.				90-	0579240			
Part I Informat	ion Conce	ning Insurance Contra	ct Coverage, Fees,	and Con	nmissions Provide inf	formation for each contract		
on a separa	ate Schedule A	 Individual contracts grouped 	as a unit in Parts II and II	I can be re	ported on a single Sched	lule A.		
1 Coverage Information:								
(a) Name of insurance ca	rrier							
UNUM LIFE INSURANCE	COMPANY OF	AMERICA						
(I.) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From	(g) To		
04.0070070	00005	000500				04/04/0040		
01-0278678	62235	629563	31		10/01/2017	01/01/2018		
2								
Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. Li	st in line 3	the agents, brokers, and	other persons in		
				/b) T				
(a) 10tal a	(a) Total amount of commissions paid (b) Total amount of fees paid							
		0				0		
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).				
	(a) Name a	and address of the agent, broke	er, or other person to whor	m commiss	ions or fees were paid			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose				
		(5)		(4.)	-	(e) Organization code		
	<u> </u>	,				•		
	(a) Name a	and address of the agent, broke	er, or other person to whor	m commiss	ions or fees were paid			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code		
		, ,				,, ,		
						_ ·		

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(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		,		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	

ı	Page	4

P	Part III Welfare Benefit Contract Information							
		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	racts are exp	erience-rated as a uni	it. Where co	ontracts cover individual	
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>	nloumont	h ☐ Prescription drug	
			=	·	=	ipioyment		
	ן ו	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Exp	perience-rated contracts:	ī					
	а	Premiums: (1) Amount received		9a(1)		2308	<u> </u>	
		(2) Increase (decrease) in amount due but unpaid		9a(2)		1142	<u></u>	
		(3) Increase (decrease) in unearned premium res	-	9a(3)		1	0.176	
		(4) Earned ((1) + (2) - (3))	The state of the s			. 9a(4)	3450	
	b	Benefit charges (1) Claims paid	•	9b(1)			_	
		(2) Increase (decrease) in claim reserves				01 (0)		
		(3) Incurred claims (add (1) and (2))				. 9b(3)	C	
	_	(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (or	· · · · · · · · · · · · · · · · · · ·	0-(4)(A)			_	
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees	•	9c(1)(B) 9c(1)(C)			-	
		(C) Other specific acquisition costs		9c(1)(D)			_	
		(D) Other expenses(E) Taxes	•	0 (4)(5)			-	
		(F) Charges for risks or other contingencies	l-				_	
		(G) Other retention charges					_	
		(H) Total retention	•	•		9c(1)(H)		
		(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				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no						
10		onexperience-rated contracts:	Thomas amount ontorou	00(2)	.,,	., 00		
	а	Total premiums or subscription charges paid to ca	arrier			. 10a		
	b	If the carrier, service, or other organization incurre						
		retention of the contract or policy, other than repo			•	. 10b		
	Spe	ecify nature of costs.	,	, ,				
_		Di Brasisian atti						
P	art							
11	Dic	id the insurance company fail to provide any inform	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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For colondor also was 200	17 or figer	wear beginning		ond a	din a 4 0 /0 / /0 = ::	_		
	For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017							
A Name of plan REVEL, INC. WELFARE	BENEFITS PLA	AN	<u> </u>		e-digit number (PN)	•	502	
C Plan sponsor's name as shown on line 2a of Form 5500 REVEL, INC. D Employer Identification Number (EIN) 90-0579240							EIN)	
		ning Insurance Contract. Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance car VISION SERVICE PLAN	rrier							
	(c) NAIC	(d) Contract or	(e) Approximate num	ber of	Po	olicy or co	ontract year	
(b) EIN	code	identification number	persons covered at e policy or contract y		(f) From		(g) To	
23-7089668	53031	30025469	118		01/01/2017		12/31/2017	
2 Insurance fee and coming descending order of the		ition. Enter the total fees and to	tal commissions paid. List	in line 3	the agents, broke	rs, and ot	her persons in	
(a) Total a	amount of comn	nissions paid		(b) To	tal amount of fees	s paid		
		1404				•	0	
3 Persons receiving com		ees. (Complete as many entries						
		nd address of the agent, broker		commiss	ions or fees were	paid		
GALLAGHER BENEFIT SE	ERVICES		108TH AVE NE STE 200 EVUE, WA 98004					
(b) Amount of sales ar	nd base	Fe	es and other commissions	paid				
commissions pai		(c) Amount	(d)) Purpose	Э		(e) Organization code	
	1157						3	
	(a) Name a	nd address of the agent, broker	, or other person to whom	commiss	ions or fees were	paid		
TRUEBENEFITS LLC			4TH AVE STE 2200 TLE, WA 98161					
(b) Amount of sales and base Fees and other commissions paid								
commissions pai		(c) Amount) Purpose	Э		(e) Organization code	
	247						3	
For Panerwork Reduction	n Act Notice s	see the Instructions for Form	5500			Schen	lule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(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 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)				
	_			, 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	art	Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such conti	acts are ex	perience-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	X Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental u	inemployment	h Prescription drug
	; [Stop loss (large deductible)	j HMO contract		PPO contract	omployon	I Indemnity contract
	' <u> </u>		I HIVIO contract	, n	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9		erience-rated contracts:	ſ		1		_
	а	Premiums: (1) Amount received	ŀ	9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_
		(3) Increase (decrease) in unearned premium res		9a(3)		0-(4)	
	L	(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid	l	9b(1)			_
		(2) Increase (decrease) in claim reserves		9b(2)		0h/2\	
		(3) Incurred claims (add (1) and (2))					
	_	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	·	00(1)(A)			_
		(A) Commissions (B) Administrative service or other fees	ľ	9c(1)(A) 9c(1)(B)			_
		(C) Other specific acquisition costs	ľ	9c(1)(C)			_
		(D) Other expenses		9c(1)(D)			-
		(E) Taxes	l	9c(1)(E)			-
		(F) Charges for risks or other contingencies	ŀ	9c(1)(F)			_
		(G) Other retention charges		9c(1)(G)			_
		(H) Total retention			-	9c(1)(H)	,
		(2) Dividends or retroactive rate refunds. (These	_	_	-		
	d	Status of policyholder reserves at end of year: (1			4		
	u	(2) Claim reserves	•			` ` `	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no					
10		nexperience-rated contracts:			- /		
	а	Total premiums or subscription charges paid to c	arrier			10a	15350
	b	If the carrier, service, or other organization incurr					
	~	retention of the contract or policy, other than repo					
	Spe	cify nature of costs.	,	, ,			-
P	art	V Provision of Information					
				-1- 0 1 :	1- 40	П Усс	V No
11		I the insurance company fail to provide any inform		ete Schedu	ıle A?	Yes	X No
12	! If t	ne 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.

OMB No. 1210-0110

2017

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					This Fo	rm is Open to Public Inspection		
For calendar	plan year 201	7 or fiscal pla	an year beginning 01/01/2017		and e	nding 12/3	1/2017	
A Name of plan REVEL, INC. WELFARE BENEFITS PLAN						ee-digit n number (PN	1) •	502
C Plan spon REVEL, INC.		s shown on li	ne 2a of Form 5500			loyer Identifica 0-0579240	ation Number	(EIN)
Part I	Informati on a separa	ion Conce te Schedule	erning Insurance Contrac A. Individual contracts grouped a	t Coverage, Fees, as a unit in Parts II and II	and Co	mmissions eported on a s	S Provide info single Schedu	ormation for each contract ale A.
1 Coverage	Information:							
(a) Name of LIFE INSURA			TH AMERICA	(a) Annuing	and a second	T	Dollovara	
(b) E	ΞIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	t end of	(f)	From	contract year (g) To
23-1503749		65498	SOK 602807	policy of contract		01/01/2017	7	12/31/2017
	fee and comn g order of the		nation. Enter the total fees and tot.	tal commissions paid. L	ist in line 3	the agents, t	brokers, and	other persons in
	(a) Total a	mount of con	nmissions paid		(b) T	otal amount o	of fees paid	
	, ,		0		•		•	4
3 Persons re	eceiving comr	nissions and	fees. (Complete as many entries	as needed to report all	persons).			
		(a) Name	and address of the agent, broker	, or other person to who	m commis	sions or fees	were paid	
GALLAGHER	BENEFIT SE	RVICE						
(b) Amou	nt of sales an	d base	Fe-	es and other commission	ns paid			
	nmissions paid		(c) Amount		(d) Purpos	se		(e) Organization code
		0	4 C	VERRIDE				3
		(a) Name	and address of the agent, broker	, or other person to who	m commis	sions or fees	were paid	
(h) Amou	nt of sales an	d hase	Fe	es and other commission	ns paid			
	nmissions paid		(c) Amount		(d) Purpos	se		(e) Organization code
		A . N					• •	/

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(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 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

P	art	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 ting purposes if such co	ontracts are expe	erience-rated as a uni	t. Where co	ontracts cover indivi	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance	;e
	е	Te	mporary disability (accident and sickness)	f Long-term disa	bility g	Supplemental unem	ployment	h Prescription	drug
	i İ	Sto	op loss (large deductible)	j HMO contract	k∏	PPO contract		I Indemnity co	ntract
	m		her (specify) ACCIDENTAL DEATH	,				ц ,	
9	Ехр	eriend	ce-rated contracts:						
	a	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	d	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	serve	9a(3)		1		
		(4) E	arned ((1) + (2) - (3))				. 9a(4)		
	b		efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				T		
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		
		` '	claims charged				. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	on an accrual basis)	[- 43443 T				
			(A) Commissions						
			(B) Administrative service or other fees		0. (4)(0)				
			(C) Other specific acquisition costs						
			(D) Other expenses		0.(4)(5)				
			(E) Taxes(F) Charges for risks or other contingencies.						
			(G) Other retention charges					_	
			(H) Total retention				9c(1)(H)	
			Dividends or retroactive rate refunds. (These	_				/	
	d		us of policyholder reserves at end of year: (1						
	u		Claim reserves	,			9d(1)		
		` '	Other reserves				9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n						
10			erience-rated contracts:			,	1		
	а		ll premiums or subscription charges paid to	carrier			. 10a		C
	b		e carrier, service, or other organization incur						
	_	rete	ntion of the contract or policy, other than replature of costs.				. 10b		
P	art	IV	Provision of Information						
				nation necessary to ac-	mnlata Sahadula	Δ2 Π	Yes	X No	
			insurance company fail to provide any inform		npiete Schedule	A?	res	NO NO	
12	. If t	he ar	swer to line 11 is "Yes," specify the informat	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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

For calendar plan year 20°	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/31/2017	
A Name of plan				B Three-digit		
REVEL, INC. WELFARE BENEFITS PLAN				plan	number (PN)	502
C Plan sponsor's name a	s shown on line	2a of Form 5500		D Emplo	yer Identification Number (EIN)
REVEL, INC.				90-	0579240	
		ning Insurance Contract. Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance car	rrier					
LIFE INSURANCE COMPA	ANY OF NORTI	H AMERICA				
	(c) NAIC	(d) Contract or	(e) Approximate no		Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
23-1503749	65498	OK 965700	47	7	01/01/2017	12/31/2017
2 Insurance fee and complete descending order of the		ntion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid		(b) To	otal amount of fees paid	
		1765				200
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s 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	
GALLAGHER BENEFITS S	SERVICE					
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose	e	(e) Organization code
	1290	200 C	OVERRIDE			3
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees were paid	
TRUEBENEFITS LLC		-	•			
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose	е	(e) Organization code
	475					3
For Paperwork Reductio	for Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule 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	
4.1.		Fees and other commissions	paid	(e) Organization
(b) Amount of sales and base commissions paid) Amount of sales and base commissions paid (c) Amount (d) Purpose			
(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 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

F	Part	III	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individuals.	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover inc	
8	Ben	efit a	nd contract type (check all applicable boxes)			-	-		
	а	Пне	ealth (other than dental or vision)	b Dental	с	Vision		d Life insura	ance
	e	=	mporary disability (accident and sickness)	f Long-term disability	=	<u>-</u>	nlovmont	h Prescription	
		_		=		=	pioyinent		•
	ַ י	_	op loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity	contract
	m	X Ot	her (specify) ACCIDENTAL DEATH						
9			ce-rated contracts:						
	a I		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res				- (1)		
		. ,	arned ((1) + (2) - (3))				. 9a(4)		
	b		efit charges (1) Claims paid		• •				
			ncrease (decrease) in claim reserves				01 (0)		
			ncurred claims (add (1) and (2))						
	_	` '	claims charged		•••••		. 9b(4)		
	С		nainder of premium: (1) Retention charges (c		0 (4)(4)				
			(A) Commissions		9c(1)(A)			_	
			(B) Administrative service or other fees		_ ,,,,			_	
			(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)			_	
			(D) Other expenses		0.74\75\			_	
			(E) Charges for risks or other continuous					_	
			(F) Charges for risks or other contingencies.		0.74\/0\				
			(G) Other retention charges(H) Total retention				9c(1)(H)		
			Dividends or retroactive rate refunds. (These					<u>'</u>	
	اہ				<u> </u>				
	d		us of policyholder reserves at end of year: (1				• •		
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				• • •		
10			dends or retroactive rate refunds due. (Do n erience-rated contracts:	ot include amount entered	in line 9c(2)	.)	. 9e		
10	_			porrior			. 10a		706/
	a		Il premiums or subscription charges paid to c				iua		7060
	b	rete	e carrier, service, or other organization incurintion of the contract or policy, other than replature of costs.				. 10b		
		cify r	ature of costs.						
P	art	V	Provision of Information						
11	l Dic	the	insurance company fail to provide any inform	ation necessary to compl	ete Schedule	e A?	Yes	X No	
12	2 If t	ne ar	swer to line 11 is "Yes," specify the informat	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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		pursuant to	ERISA Section 103(a)(2)	•			Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and er	nding 12/3	1/2017	
A Name of plan REVEL, INC. WELFARE	DENEEITS DI	A NI			e-digit		502
REVEL, INC. WELFARE	DENEFITS PL/	AIN		plan	number (PI	<u>1)</u>	502
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
REVEL, INC.	REVEL, INC.						
		rning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
-							
(a) Name of insurance ca		NOT COMPANY					
THE LINCOLN NATIONAL	LIFE INSURA	NCE COMPANY					
	(-) NIAIO	(I) O a start to a	(e) Approximate nu	ımber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f)	From	(g) To
35-0472300	65676	000010208742	policy or contrac	•	01/01/201	7	12/31/2017
2 Insurance fee and com- descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents,	brokers, and o	other persons in
	amount of com	missions paid		(b) To	otal amount	of fees paid	
, ,		7998		` ,		·	0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
<u> </u>		and address of the agent, broker			ions or fees	were paid	
GALLAGHER BENEFIT SE			,				
		Γο	as and other commission				
(b) Amount of sales ar		(c) Amount	es and other commission	is paid (d) Purpos	^		(a) Organization and
commissions pa	5976	(C) Amount		(u) Puipos	U		(e) Organization code
	3970						3
	/				. ,	.,	
TOUEDENEETTOU	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	sions or fees	were paid	
TRUEBENEFITS LLC							
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	2022						3
For Denominants Destroy	m Aat Nation	and the Instructions for Francis	FEOO			Call a	dule A (Farm FF00) 0047
For Paperwork Reduction	III ACT NOTICE,	see the Instructions for Form	ວວບບ.			Scne	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) Organization
(b) Amount of sales and base commissions paid) Amount of sales and base commissions paid (c) Amount (d) Purpose			
(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 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)				
	_			, 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	art l	III Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same graph the information may be combined for reporting employees, the entire group of such individual	g purposes if such conti	acts are expe	erience-rated as a unit	t. Where co	ontracts cover individu	
8	Bene	nefit and contract type (check all applicable boxes)		-	<u> </u>	-		
	а		b Dental	С	Vision		d Life insurance	
	_ 		f X Long-term disabilit	<u> </u>	<u>.</u>	nla mant	h Prescription dr	
	e [Supplemental unem	pioyment		-
	י ו	Stop loss (large deductible)	HMO contract	k_	PPO contract		I Indemnity cont	ract
	m	Other (specify)						
9	Expe	perience-rated contracts:	Ī					
		Premiums: (1) Amount received	i	9a(1)				
		(2) Increase (decrease) in amount due but unpaid.		9a(2)				
		(3) Increase (decrease) in unearned premium rese		9a(3)		2 (0)		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid	ľ	9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)		05/2)		
		(3) Incurred claims (add (1) and (2))				9b(3) 9b(4)		
		(4) Claims charged				90(4)		
	С	(A) Commissions	·	9c(1)(A)				
		(B) Administrative service or other fees	ŀ	9c(1)(A)				
		(C) Other specific acquisition costs	ŀ	9c(1)(C)				
		(D) Other expenses	ľ	9c(1)(D)				
		(E) Taxes						
		(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	mounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	_	_		9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2)	.)	9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			. 10a		39989
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repor				10b		
	Spe	retention of the contract or policy, other than repor ecify nature of costs.	ted in Part I, line 2 abov	e, report amo	unt	. 106		
_		N/ Brestein (I f = 2						
P	art I	IV Provision of Information			-			
11	Dic	id the insurance company fail to provide any informa	tion necessary to compl	ete Schedule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify 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

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017								
A Name of plan				B Three-digit				
REVEL, INC. WELFARE BENEFITS PLAN			plan number (PN) 502					
C Plan sponsor's name a	as shown on line	2a of Form 5500		D Emplo	yer Identification Number	(EIN)		
REVEL, INC.				90-	0579240			
	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		NCE COMPANY						
(b) EIN	(c) NAIC	(d) Contract or		e) Approximate number of		Policy or contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From	(g) To		
35-0472300	65676	000010208743	7	7	01/01/2017	12/31/2017		
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and o	ther persons in		
(a) Total	amount of comn	nissions paid		(b) To	otal amount of fees paid			
		1265				0		
3 Persons receiving com	missions and fe	es. (Complete as many entries	s 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			
GALLAGHER BENEFIT S	ERVICES INC							
(b) Amount of sales a	nd base	Fe	es and other commission	sions paid				
commissions paid		(c) Amount	(d) Purpose		e	(e) Organization code		
	909					3		
	(a) Name a	nd address of the agent, broker	or other person to who	m commiss	ions or fees were paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid TRUEBENEFITS LLC								
(b) Amount of sales and base Fees and other commissions paid								
commissions paid		(c) Amount		(d) Purpose		(e) Organization code		
356						3		
For Paperwork Reduction	on Act Notice, s	see the Instructions for Form	5500.		Sche	dule A (Form 5500) 2017 v. 170203		

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(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) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(0	(d) Purpose	
(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			
(b) Amount of sales and base		Fees and other commissions p	paid d) Purpose	(e) Organization
commissions paid	(c) Amount	((code	
(a) Na	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	(e)
(b) Amount of sales and base commissions paid	(c) Amount		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 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	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	

ı	Page	4

P	art	III Welfare Benefit Contract Informa	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	perience-rated as a un	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
	L	Temporary disability (accident and sickness)	f Long-term disabilit	L	Supplemental unen	anlaymant	h ☐ Prescription drug
	e					іріоуптепі	=
	ן י	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9		erience-rated contracts:		- (1)	1		
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res	•	9a(3)		0-(4)	
	h	(4) Earned ((1) + (2) - (3))	i			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1) 9b(2)			_
		(2) Increase (decrease) in claim reserves				9b(3)	
		(4) Claims charged				9b(3)	
	С	Remainder of premium: (1) Retention charges (o				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		9c(1)(D)			
		(E) Taxes		0 (4)(5)			_
		(F) Charges for risks or other contingencies					
		(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	_	_		` '	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2) .)	9e	
10	No	nexperience-rated contracts:					
							6325
	b	If the carrier, service, or other organization incurr					
	C	retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report am	ount	10b	
	Specify nature of costs.						
P	art	IV Provision of Information					
			notion nocessary to several	oto Cobe del		Yes	X No
11		d the insurance company fail to provide any inform		ete Scheaul	e A?	163	<u> </u>
14	: It t	he answer to line 11 is "Yes," specify the informati	on not provided.				